RESOURCE AND PATIENT MANAGEMENT SYSTEM

Third Party Billing
(ABM)

User's Guide

Version 2.5
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Division of Information Resources
Albuquerque, New Mexico

PREFACE

This document's purpose is to provide guidance to users of the Third Party Billing (ABM) system.

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1 Introduction

1.1 Overview

The Third Party Billing System (ABM) is designed to automate the creation of a claim using existing RPMS data. In ABM, you can edit files and claims; print a UB-92, HCFA 1500, or ADA Dental form; or create an electronic UB-92 file. The system prints bills for private insurance, Medicare, Medicaid, and non-beneficiary (self-pay) patients. ABM also supports the RPMS Accounts Receivable (BAR) package.

In ABM, the claims can be created manually or automatically. You can generate multiple forms for the same claim and year 2000-compliant electronic media claims. ABM also allows you to override a manual cancellation so the Claim Generator will create a new claim with the same claim number.

Because patients can be seen as an outpatient and an inpatient on the same day, the ABM package combines these visits into one inpatient claim for Medicaid and Medicare. This eliminates billing two separate visits on one day for which only one is paid (the first one that reaches the insurer.) All billable items are placed on ONE claim per inpatient stay.

ABM has a flexible design that accommodates billing to a specific payer's requirements or a unique contractual agreement. You may select a primary billing entity, rebill any secondary insurers, and back-bill for physician inpatient services. ABM provides the use of coverage types to prevent unreimburseable billing. Error checking prevents submission of erroneous bills, and you can define the conditions for the error checking. You may also associate all prescribed medications with a dispense fee that is automatically added to the drug cost. Finally, ABM allows generation of a separate bill for each page of the Claim Editor, making it possible to generate professional component bills that must be on a separate form but are sent to the same payor.

In ABM visits are “orphaned” when they are not linked to a complete PCC visit. This type of visit can occur when another RPMS package linked to PCC performs a service as a separate visit (e.g., a patient may go to the lab to get blood drawn) creating an unknown purpose of visit (POV) and/or provider. ABM creates a claim if the ordering provider is available (and ensures the provider is billable before creating a claim); the POV can be left blank. Note that a recent survey at Alaskan Native Medical Center (ANMC) found 40% (approximately $20 million) of their lab visits were orphans.

Using complete fee schedules for all applicable Common Procedural Terminology (CPT) codes and Revenue Codes including Medicare's Ambulatory Surgery schedule allows the ABM system to better identify the level of care during a patient visit and provide more accurate billing. In the ABM system, you can also designate and sequence International Classification of Diseases – 9th revision (ICD9) diagnosis and procedure information. Separate line items for middle days of care accommodate different levels of care on

different days. Lab links allow capture of CPT codes for panels and atomic tests from Patient Care Component (PCC) lab, micro, and path files.

> **Note**: For the data to be transferred to Third Party Billing, Lab 5.2 needs to be installed and operational.

1.2 New in Version 2.5

ABM version 2.5 is primarily a maintenance release including released version 2.4 patched through patch 10. Additionally, this version supports FileMan version 21 and 22. Other enhancements include auto-approve dental claims, additional modes of export and files that support claim submission to Envoy/ Web MD, and a new file that will prevent local modifications from being overwritten by future ABM versions.

1.3 Package Orientation

Login/Logout Procedures
If nothing appears on your screen when you turn on your terminal, press the Return key. Within a few seconds, the (Site Name) Login prompt should appear. The system is asking for your UNIX login code provided by your site manager. Enter it and press the Return key.

The system will next prompt you for your Access Code, then your Verify Code. Type each code at the appropriate prompt, pressing the Return key after each. Note that as you type, nothing appears on the screen. This is to prevent anyone from learning your access code by watching you log onto the system. If an unfamiliar menu appears on your screen, contact your supervisor or site manager at once. The site manager controls login procedures and access to the system. This is to insure that only authorized personnel gain entry to the system.

When the menu appears, press the Caps Lock key to make sure that only capital letters are entered as you type.

Keyboard Entry
The keyboard has two main sections. The first section contains a keyboard similar to a ten-key-adding machine. This section makes up the right end of the keyboard. The left section of the keyboard resembles a typewriter keyboard with the addition of several special keys and symbols. It is this section and its special keys that you will normally use.

When entering numbers, you may use either the numeric keys at the right end of the main keyboard or the numeric keys on the top of the typewriter-like keyboard.

If you enter an incorrect response, the system beeps to alert you to the error. A message following the beep shows the type of error; another one requests the correct information.

Capital Letters
When entering data onto the system, make sure you type all letters and words in CAPITAL LETTERS. Set up your terminal to enter only capital letters. Do this by pressing down the Caps Lock key. This will limit all entries to capital letters only. Note that the Caps Lock key has no effect on the numeric keys. It affects only the letters a-z.

Key Usage

Return Key
Press the Return key to show the end of an entry such as a number or a word. Press the Return key each time you respond to a computer prompt. If you want to return to the previous screen, simply press the Return key without entering a response. This will take you back to the previous menu screen.

> **Note**: The Return Key on some keyboards is shown as the Enter Key. The Return key and the Enter key can be used interchangeably but will only be referred to as the Return key in this document.

Backspace Key
The backspace key allows you to move the cursor backwards (to the left). It deletes or erases characters as the cursor moves to the left.

Space Bar Key
In some instances, you may want to use a shortcut during data entry. Use the space bar key to tell the system to reuse a previous response. For example, when you are asked to make a selection from a menu of choices, press the space bar key and the Return key. This tells the system to reuse the last selection you made.

Up-hat (^)
Type the up-hat (^) by pressing the Shift key and the 6 key (on the standard keyboard, not on the number pad). This special control character will allow you to exit from a particular activity or data entry sequence. Typing the up-hat (^) at any prompt will usually take you back to the proceeding prompt or menu level. You can also use the up-hat key to exit from long data displays such as vendor lists that usually involve many screens.

Hold Screen Key (F1)
Press the Hold Screen key to halt the display of data on your terminal screen temporarily. This key is labeled F1 and is located in the upper left corner of the keyboard. Pressing this key once will halt the display, allowing you to read the information on the screen. Pressing it a second time will resume the scrolling of the data. This key is useful when reviewing a long list of data. Never leave your

Special Delete Character (@)
Use the @ symbol to delete an existing entry in a file. To type the @ symbol, press the Shift key and the 2 key at the top of the keyboard. Type the @ symbol after selecting the record you wish to delete or when positioned at a specific field that you wish to delete. The system prohibits deletion of certain records or deletion of data contained in certain fields.

Using the Help Display
Special help displays are available for most menu options and data entry prompts. Typing a single question mark (?) at the data entry prompt produces instructions for entering requested data. Typing two question marks (??) causes the system to display a more complete message. Some prompts display a list of available choices.

When choosing from a menu of options, type three question marks (???) after the prompts to bring up a brief explanation on how to respond to each option. Entry of a single question mark (?) followed by the option number or name causes the system to display a detailed description of that particular option. This only occurs if help screens are available for that option.

Previous and Default Responses
Some computer prompts display either a single slash (/) or a double slash (//) at the end. When you see a single slash, type in a new response or enter a response previously accepted by the system. Press the space bar key once to enter a previously accepted response, if the prompt will accept it. Names or dates are examples of responses entered through this method to save time in data entry.

If a prompt contains a default value and a double slash, accept the default value by pressing the Return key. For example, when prompted with a Yes/No question like this one:

```
DO YOU WISH TO CONTINUE? YES//
```

You can press the Return key to accept YES (the default before the two slashes (//) as your answer. If you wish to enter a NO response instead, you must type N or No after the slashes (//) and press the Return key.

Time And Date Conventions
When a system prompt calls for an entry involving a specific date or time, you may enter the information in several ways:

Date
Simply typing a T in response to a date prompt instructs the system to use the current date. Typing a T with a + or a - value instructs the system to use today's date plus or minus the indicated number of days. For example, if today's date is May 20, 2002, entering T-10 would instruct the system to use the date of May 10, 2002.

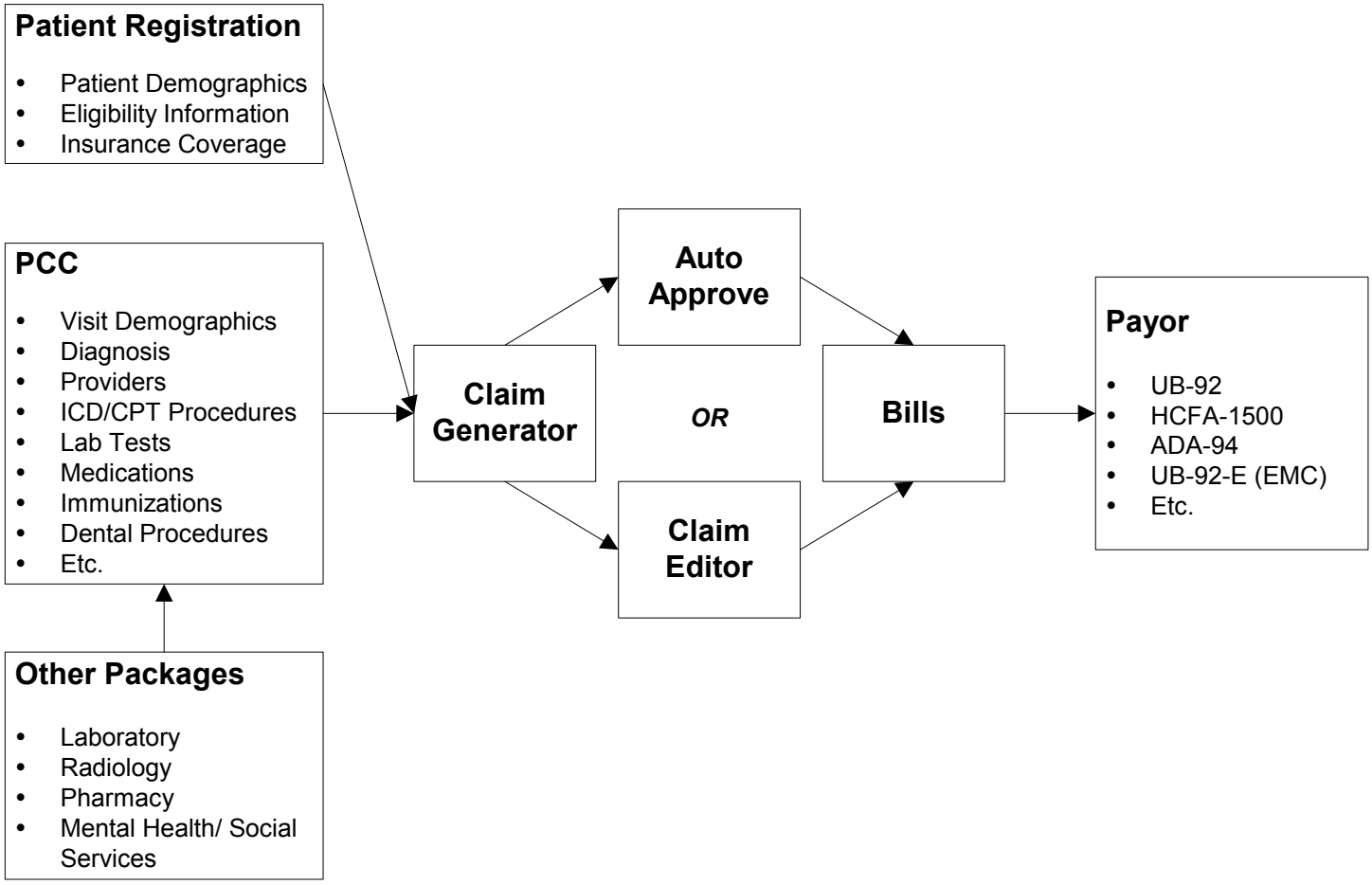
You can enter dates several ways. To enter May 20, 1995 you may use 20 May, 1995; 05/20/95; or 05-20-95. Select one style of date entry and use it consistently. Choose the form that you find easiest to use.

Time
You also may enter time in several ways. Unless otherwise shown, the system assumes that all times fall between the hours of 6:00 a.m. and 6:00 p.m. For example, if you enter 3 at the time prompt, the system automatically converts this to 3:00 p.m. An entry of 9 becomes 9:00 a.m. If you need to enter a time such as 9:00 p.m., you must type in the entire entry.

Date/Time
You may enter any valid combination of date and time by using the conventions described above with an "@" symbol between the date and time. For example, if the current date was May 20, 2002 and you wished to make an entry using that date and a time of 3:00 p.m., you could enter the information in any of the following ways:

- 5/20/95 @ 3
- 052095 @ 3:00 PM
- T @ 3:00

1.4 Third Party Billing Data Flow



1.5 Security and User Identification

Site managers are responsible for assigning access and verification codes to everyone selected to have entry to the A/R package. These codes serve several functions. It is very important to make sure that only authorized individuals access the confidential information stored in the system. **Never reveal your access code to anyone.** If you believe someone else is using your access code to gain unauthorized entry to the system, inform your supervisor.

Another function of your access code is for easy identification. This makes it easy for the system to take you directly to menus you normally work with.

2 Menu Description

Selecting the ABM package will display the ABM main menu.

```
   EDTP   Add/Edit Claim Menu…
   MGTP   Claim/Bill Management Menu…
   RPTP   Reports Menu…
   PRTP   Print Bills Menu
   TMTP   Table Maintenance Menu…
   ELTP   Eligibility Menu…
   PPTP   Payment Posting
   EMTP   Electronic Media Claims…
   SSTP   Set Site
Select Third Party Billing System Option:
```

Figure 2-1: Third Party Billing Main Menu

The main menu and submenu options are outlined in the chart below. The main menu options are noted in bold. The submenu options are listed below the corresponding main menu option with brief descriptions of their functions to the right.

EDTP: Add/Edit Claim Menu

|__CGIP – Claim Generator, One Patient	Create a claim for a specified patient (used for point of service billing).
|__EDCL – Edit Claim Data	Edit one claim at a time.
|__LOOP - Claim Editor Loop	Edit data for all claims meeting specified exclusion parameters.
|__ NEW - Add New	Manually add a new claim to the system.
|__ RBCL - Rebuild Items from PCC	Rebuild a specified portion of the claim with data from the PCC system.

MGTP: Claim/Bill Management Menu

|__ CLMG - Cancel Claim	Cancel a claim when it is unbillable or when all billing on it has been completed.
|__ BIMG - Cancel an Approved Bill	Cancel a bill that has errors in it, then correct it through the Claim Editor option.
|__ IQMG - Inquire about an Approved Bill	Display the fields in a bill to investigate the values they contain.
|__ MRMG - Merge Claims	Merge two or more claims into one claim.
|__ BKMG - Initiate Back Billing Check	Scan all visits back to a specific date to

	determine if they have been billed.
|__ ADMG - Add a new bill that was manually submitted	Enter a bill that was submitted manually so the system can track and manage it.
|__ AOMG - Export Bills to Area Office Tracking System	Manually transfer bills to the Area office tracking system.
|__ FRMG - Flat Rate Adjustment	Globally change the flat rate for a specified insurer and visit type beginning on a specified visit date.
|__ OCMG - Open/Close Claim	Re-open a previously closed claim or close an open claim.
|__ RCCP - Recreate claim from PCC data	Recreate a claim with the same claim number as one cancelled by the Claim Generator.
|__ SCMG - Split Claim	Split certain pages of one claim off into another. (e.g., billed via a pharmacy form to a separate payor.)

RPTP: Reports Menu

|__ BRRP - Brief (single-line) Claim Listing	List claims sorted by visit type or clinic name.
|__ SURP - Summarized (multi-line) Claim Listing	Display a summary of claims specified which includes providers, ICD procedures, diagnosis, and insurers.
|__ DERP - Detailed Display of Selective Claims	Print all claim pages that have data exactly as they appear in the claim editing process, including errors.
|__ PRRP - Employee Productivity Listing	List number of claims and amounts billed by individual or all employees in a selected location.
|__ BLRP - Bills Listing	List unpaid, paid, incomplete, or all bills with claim numbers, export dates, and billed/paid amounts.
|__ STRP - Statistical Billed-Payment Report	Print a summary report for all bills sorted and tallied by facility name and visit type.

PTRP - Billing Activity for a Specific Patient	Display the billing activity for a specific patient; can exclude completed bills.
DXRP - Listing of Billed Primary Diagnosis	Print a list of primary diagnoses showing the billed amount and percent of the total amount per diagnosis.
PXRP - Listing of Billed Procedures	Print a list of procedures showing the billed amount and percent of the total amount per diagnosis.
CHRP - Charge Master Listing	Print a summary report of all items in the Charge Master.
PARP - PCC Visit Tracking/Audit	Display for each visit the patient name, location, HRN, eligibility, and reason that the visit is unbillable.
VPRP - View PCC Visit	Display a list of visits for a patient and all PCC visit data for any selected visit.

PRTP: Print Bills Menu

AWPR - Bills Awaiting Export Report	Display a list of bills that have a claim status of approved.
EXPR - Print Approved Bills	Print bills that have been approved and are ready to be sent to an insurer.
WSPR - Print Worksheet (Itemized CPT Data)	Print the worksheet (detailed claim display) for a single claim, list of claims, or the entire export (print) batch.
MLPR - Print Mailing Address Labels	Print insurer-mailing labels by individual insurers or in a batch.
REPR - Reprint Bill	Reprint a single bill or a list of bills, all bills for an export batch, or unpaid bills.
TRPR - Transmittal Listing	Obtain a list of all entries (bills) contained in an export batch.
TSPR - Test Forms Alignment	Test the alignment of specified forms in the printer before actually printing them.

TMTP: Table Maintenance Menu

|__ FETM - Fee Schedule Menu	Update your own fee schedules that contain charges for goods or services rendered.
|__ CPTM - CPT File Menu	Update and manage the CPT file.
|__ PRTM - Inquire to Provider File	Display all information contained in the Provider file for a selected provider.
|__ LOTM - Location File Menu	Update and manage location information.
|__ INTM - Insurer File Menu	Update and manage insurer information.
|__ COTM - Coverage Type File Menu	Manage coverage types and identify those providers, clinics, and diagnoses that are unbillable.
|__ SITM - Site Parameter Maintenance	Define criteria particular to a certain site.
|__ ERTM- Error Codes Menu	Edit and list contents of the error code file.
|__ GRTM - Group Insurance Plans Menu	Manage, add, edit, list, or merge group insurance group numbers.
|__ RVTM - Revenue Codes Menu	Edit and print revenue codes.
|__ UCTM - UB-92 Codes Menu	Inactivate a UB-92 code and list all UB-92 codes.
|__ EMTM - Employer File Menu	Add/edit an employer, list employers or their employees, or merge duplicate employers.
|__ DRTM - Drug File Menu	Display the drug file contents with NDC number and dispense fee or display details of a single drug.
|__ VITM - Visit Type Maintenance	Create new visit types or edit existing types.
|__ CMTM - Charge Master Add/Edit	Enter or change billable goods and services, including supplies, CPT procedures, etc. Supports bar coding.
|__ DMTM - Dental Remap Table Maintenance	Recode Indian Health Service (IHS) dental codes by insurer.

|__ FLTM - Form Locator Override	Customize insurer and visit type information on the HCFA-1500 forms (not available in V 2.0).
|__SSTM - Initialize New Facility	Initialize a new location for the Third Party Billing Package.

ELTP: Eligibility Menu

|__ EDEL - Edit a Patient Registration Third Party Page	Edit Medicare, Medicaid, Railroad Medicare, and private insurance eligibility in the Patient Registration system.
|__ POEL - Private Insurance Policy Maintenance Menu	Add, edit, list, and merge private insurance policies through the Patient Registration system.
|__ RPEL - Eligibility Reports Menu	Access the eligibility reports in the Patient Registration system and list various categories of patients.

PPTP: Payment Posting	Post payments. (If the BAR system is being used, post them through that package instead.)

EMTP: Electronic Media Claims

|__ BSEM - Batch Summary	Review the billing information of batches already created.
|__ CREM - Create EMC File	Create an EMC file containing bills that have been approved but have not been included in a previous EMC batch.
|__ RCEM - Re-Create an EMC File	Re-create an EMC file when necessary (e.g., if the original file is lost).
|__ SUEM - Summary of Bills Ready for Submission	Display summary or detail information of bills already approved but that are not included in an EMC batch.

SSTP: Set Site	Switch between sites

3 Main Menu

The Main Menu contains security locks on all options that allow data manipulation or export. Whether a particular user has access to an option is at the discretion of the Site Manager.

```
+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
|            THIRD PARTY BILLING SYSTEM                                  |
+                    V 2.5                                               +
|                     SELLS HOSP                                          |
+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
User: DANIELSON,RODNEY                  18-MAR-1991 11:34 AM

   EDTP   Add/Edit Claim Menu…
   MGTP   Claim/Bill Management Menu…
   RPTP   Reports Menu…
   PRTP   Print Bills Menu
   TMTP   Table Maintenance Menu…
   ELTP   Eligibility Menu…
   PPTP   Payment Posting
   EMTP   Electronic Media Claims…
   SSTP   Set Site
```

Figure 3-1: Third Party Billing Main Menu

To select an option, type enough of the option synonym or the option name to uniquely identify it. For example, entering TM uniquely identifies the Table Maintenance Menu option. An effort has been made to provide unique menu option synonyms that are easy to remember to facilitate the Kernel "up-hat jump." This relational feature allows the user to jump from the current menu directly to an option in another menu without having to navigate through the menu tree. To accomplish this, type an up-hat (^) followed by the synonym of the desired option.

3.1 Main Menu Entrance Checks

When the billing system is first implemented, the following message will be displayed on the main menu until the Site Parameters file has been reviewed.

```
SITE PARAMETERS have not yet been reviewed. Access to the Claim Editor is
prevented until they are! The Site Parameters can be reviewed through the Table
Maintenance Menu.
```

Figure 3-2: Notice to Review Site Parameters

Upon entrance into the main menu, the system will examine the successful operation of the nightly Claim Generator.

```
WARNING: The Claim Generator has not run since Jan. 19, 1997.
Contact your Site Manager to investigate this problem.
```

Figure 3-3: Claim Generator Status Message

If the Claim Generator has not run in more than a day, the message in Figure 3-3 will be displayed on the main menu to alert and notify you of the appropriate action to take.

4 Add/Edit Claim Menu (EDTP)

Main Menu → EDTP

The options on the Add/Edit Claim menu allow the user to invoke the Claim Generator for one specified patient (CG1P), edit data for one specified claim (EDCL), edit data for all claims meeting specified exclusion parameters (LOOP), manually add a new claim (NEW), and rebuild a specified portion of the claim with data from the PCC system (RBCL). The creation of a claim can be done manually or automatically. In the automatic mode, the ABM system checks visits nightly against the eligibility files and creates a claim for each match using the visit information.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |         THIRD PARTY BILLING SYSTEM - VER 2.5            |
          +                    Add/Edit Claim Menu                  +
          |                         SELLS HOSP                      |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: MAROFSKY,SANDRA                    4-FEB-1997 10:30 AM


   CG1P   Claim Generator, One Patient
   EDCL   Edit Claim Data
   LOOP   Claim Editor Loop
   NEW    Add New Claim (Manual Entry)
   RBCL   Rebuild Items from PCC

Select Add/Edit Claim Menu Option:
```

Figure 4-1: Add/ Edit Claim Menu

The claim system allows for data manipulation via an editor that is comprised of multiple pages, each for a different data category. Figure 4-2 lists all pages contained in the Claim Editor.

CLAIM PAGES

Page	Category Description	Page	Category Description
0	Claim Summary	8D	Medications
1	Claim Identifiers	8E	Laboratory Services (CPT)
2	Insurers	8F	Radiology Services (CPT)
3	Questions	8G	Anesthesia Services (CPT)
4	Provider Data	8H	Misc Services (HCPCS)
5A	Diagnosis Data (ICD)	8I	Inpatient Dental (ADA)
5B	Procedure Data (ICD)	8J	Charge Master
6	Dental Services (ADA)	9A	Occurrence Codes
7	Inpatient Data	9B	Occurrence Span Codes
8A	Medical Procedures (CPT)	9C	Condition Codes
8B	Surgical Procedures (CPT)	9D	Value Codes
8C	Revenue Code	9E	Special Program Codes
		9F	Remarks

Figure 4-2: Listing of Claim Pages

Users may choose one of two menu items to guide them through the Claim Editor option. They may use the Claim Generator, One Patient (CG1P) option to edit claim data one patient at a time or use the Claim Editor Loop (LOOP) option to cycle through claims that are awaiting approval. Both of these options use the claim editor commands outlined in section 4.1.

4.1 Claim Editor Commands

Each page of the claim editor is controlled by a command processor. The commands available for a specific page vary depending upon the functionality required for that page. An abbreviated list of available commands are enclosed within parenthesis following the "Desired Action" prompt. A narrative description of each command can be obtained by entering the question mark (?) character at the "Desired Action" prompt.

```
Desired ACTION (View/Appr/Next/Jump/Quit): N//?

      Choose from one of the following actions:

          Edit - Edit Information in the Current Screen
          Add  - Add a new Entry to a Page
          Seq  - Modify the Priority Sequence
          Pick - Select Insurer to Bill
          View - Display Detailed Information
          Appr - Approve Claim for Billing
          Jump - Jump to a desired Edit Screen
          Next - Go on to the Next Edit Screen
          Back - Backup to the Previous Edit Screen
          Quit - Stop Editing the Data of this Claim
          Del  - Delete on Existing Entry
          Mode – Change mode of Export for this page

      Enter First Character of the Desired Action.
```

Figure 4-3: Listing of All Claim Commands

Commands that require a numeric selection can be completed in a single step by appending the desired numeral to the action. For example, to jump to page 2, type J2 at the "Desired Action:" prompt.

4.1.1 Page Navigation

Navigating through the claim pages is accomplished by using the NEXT, BACK, JUMP or QUIT commands. The NEXT command moves the user to the next page, the BACK command moves the user to the previous page, the JUMP command moves the user to a specified page, and the QUIT command exits the user from the claim.

The JUMP command allows the user to move directly to a specified page, as shown in the following example.

```
Desired ACTION (View/Appr/Next/Jump/Quit): N//J

Desired SCREEN (0/1/2/3/4/5/7/8/9): ?

      0 - Claim Summary
      1 - Claim Identifiers
      2 - Billing Entities
      3 - Questions
      4 - Provider Data
      5 - ICD Diagnosis/Procedures
      6 - Worksheet Data (CPT)

      Enter the Number of the Desired Screen.
```

Figure 4-4: Page Jumping Example

Jumping to pages that are suffixed with an alphabetic character (i.e., 8D Medication Page) can be accomplished by following the JUMP command with the appropriate alpha character.

4.1.2 ADD and DELETE Commands

The ADD and DELETE commands are available on all pages that allow for multiple entries.

To add an entry, select the ADD command and answer all required fields that are prompted. Examples of adding entries are presented throughout this section.

To delete an item on any page except Page 4 (Provider), select the DELETE command option and type the sequence number of the entry to be removed. To delete an item on the provider page, select the DELETE command and type the name of the provider to be removed.

```
Desired ACTION (Add/Del/Edit/Seq/View/Next/Jump/Back/Quit): N//D

Sequence Number to DELETE: (1-3): 2

Do you wish 550.93 DELETED? NO
```

Figure 4-5: Delete Command Example

4.1.3 EDIT Command

The EDIT command allows the user to alter existing data, either by selecting a particular field number or a sequence number for editing a series of fields.

On pages that contain fields of differing data elements, each field will be preceded by a number enclosed in brackets. When the user types a number after the EDIT command, he or she can edit the respective field. Pages that are comprised of a multiple with a varying number of entries that can be added or deleted will also be preceded with a sequence number. Selecting a sequence number allows the user to alter all of the editable data within that multiple.

```
Desired ACTION (Edit/Next/View/Jump/Back/Quit): N//E

Desired FIELDS: (1-11): 1-11//6-8,11

[6] Discharge Date.........: OCT 12,1990// <RETURN>
[7] Discharge Status Code..: 01// <RETURN>
[8] Discharge Hour.........: 14// <RETURN>
[11] PRO Approval Code..... : 05// <RETURN>
```

Figure 4-6: Selecting Fields to Edit Example

The example in Figure 4-6 illustrates how to select fields for editing. In this example, fields 6, 7, 8, and 11 were selected. When the user wishes to edit only one field or only the fields

associated with a multiple sequence number, the EDIT command can be completed in a single step by combining the EDIT command and the field number (i.e., type E4 to edit field 4).

4.1.4 MODE Command

This action command is only available on page eight. Each type of procedure may have a different mode of export.

4.1.5 SEQUENCE, APPROVE and PICK Commands

The SEQUENCE, APPROVE and PICK actions are specific to the diagnosis, claim summary, and insurer pages respectively. Examples of these commands being used can be found in their respective sections.

4.1.6 VIEW Command

The VIEW command provides users with a tool to conveniently obtain additional information and display errors, warnings, and corrective actions.

The only exception to this functionality is on page 0 (Claim Summary) where the VIEW command allows the user to create a printout of the entire claim, the claim errors, if the claim was automatically created, a listing of the original PCC or Ambulatory Patient Care (APC) visit, or the health summary.

```
Desired ACTION (View/Appr/Next/Jump/Quit): N//V

      Select one of the following:

           1         DETAILED CLAIM LISTING
           2         ERROR LISTING ONLY
           3         PCC VISIT DISPLAY
           4         HEALTH SUMMARY

Enter DESIRED REPORT: 2// <RETURN> ERROR LISTING ONLY

Output DEVICE:
```

Figure 4-7: Claim Summary (Page 0) View Option

In the example in Figure 4-7, the desired listing can be displayed on screen (by pressing the Return key at the "Device:" prompt) or sent directly to a system printer.

If the user entered the claim manually, options 3 and 4 (Figure 4-7) would not be available for selection. These options are based on PCC data that is not added when a claim is entered manually.

The listing in Figure 4-8 illustrates two conditions of concern: one designated as an error and the other as a warning. For the claim to be approved for billing, either the condition that is causing the error message to occur will have to be resolved or the error will have to be downgraded to a warning.

```
         ----------------- PAGE E -------------------------
Patient: DANIELSON,RODNEY [HRN: 1121]            Claim Number:  5
........................... (ERROR LISTING) ......................
                          PAGE 5A - DIAGNOSIS

ERROR:077 - PRINCIPAL DIAGNOSIS CODE UNSPECIFIED
-------------------------------------------------------------------
                        PAGE 8B - SURGERY PROCEDURES

WARNING:163 - NO CORRESPONDING CPT CODE FOR AN ICD PROCEDURE ENTERED THRU PCC
-------------------------------------------------------------------
```

Figure 4-8: Listing of Claim Errors

The corrective action for an error or warning can be displayed by typing the number associated with the error or the narrative description at the "Enter Error/Warning Number For Corrective Action (if Desired):" prompt.

```
  ===================================================================
Fatal ERRORS Exist a Bill cannot be Generated until it is Resolved!
 ===================================================================

 Enter ERROR/WARNING NUMBER for CORRECTIVE ACTION (if Desired): 58

                  (ERROR:58 RELEASE OF INFORMATION UNOBTAINED)
-------------------------------------------------------------------------------
  Corrective Action: If the Patient signed the Release of Information
                     form than [J]ump to the Questions Page (3) and
                     [E]dit the field to be YES.
-------------------------------------------------------------------------------

 Enter ERROR/WARNING NUMBER for CORRECTIVE ACTION (if Desired):
```

Figure 4-9: Displaying Corrective Actions

If an error or warning condition occurs, its corresponding message is displayed at the bottom of the applicable page to inform users of the situation. All errors must be resolved before the claim can be approved. Warnings messages are displayed only for information purposes and do not prevent claims from being approved. Errors and warnings can be defined through the Error Codes menu (section 8.9).

4.1.7 PAGE 0 - Claim Summary

The Claim Summary page presents an abbreviated summary of key information in the claim. This page is particularly useful when billing Medicare or Medicaid because the majority of the information necessary to approve a claim is displayed here.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 0  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DANIELSON,RODNEY  [no HRN]                          Claim Number: 1
.............................. (CLAIM SUMMARY)..............................

_______ Pg-1 (Claim Identifiers) _____________________ Pg-4 (Providers) ___________
Location..: ALBUQUERQ HO                | Attn: MEDICAL,DOCTOR
Clinic....: OPTOMETRY                   |__________ Pg-5A (Diagnosis) ___________
Visit Type: INPATIENT                   | 1) CATARACTS BOTH EYES
Bill From.: 10-01-1990 Bill             | 2) BILATERAL HERNIA RECURRING
            Thru: 10-12-1990            |
________ Pg-2 (Billing Entity) _________|________ Pg-8 (CPT Procedures) ________
BLUE CROSS OF CALIFORNIA      ACTIVE    | 1) REREPAIR INGUINAL HERNIA
NEW MEXICO MEDICAID           PENDING   | 2) INCISE SKULL FOR SURGERY
MONTANA MEDICAID              PENDING   | 3) OFFICE/OP VISIT, NEW, COMPRH
___________ Pg-3 (Questions) ___________| 4) OFFICE/OP VISIT, EST, BRIEF
Release Info: YES   Assign Benef: YES   | 5) OFFICE/OP VISIT, EST, EXTEND
Emrg Related: YES   Empl Related: YES   | 6) X-RAY EXAM OF MIDDLE EAR
                                        | *** additional procedures exist ***
________________________________________|_____________________________________

*** Claim File ERRORS exist use the VIEW command to list them. ***

Desired ACTION (View/Appr/Next/Jump/Quit): N// <RETURN>
```

Figure 4-10: Claim Summary Page

The procedure type (page 8) displayed on this page will vary from ICD, CPT, to ADA depending on the type of visit and the primary insurer's billing requirements.

Claim Data Checks

Prior to a user entering the Claim Summary screen (page 0), the system performs checks for errors and eligibility.

```
            ...<<< Processing, Claim Error Checks >>>...

  ...<<< Checking Eligibility Files for Potential Coverage >>>...
```

Figure 4-11: Page 0 Data Checks

The error check scans all pages in the claim for errors. If errors are found, the user is notified and the claim is put in an un-approvable status, pending resolution of these errors.

Eligibility data is also checked to make sure that it is consistent with the patient's registration information. If the claim data is inconsistent, the appropriate insurer(s) will be added or deleted (if in active or pending status), accordingly. In other words, the claim data is adjusted to reflect the patient's current eligibility. If no eligibility is found in the Patient Registration system, the user is not allowed to edit the claim.

Claim Approval

Claims can only be approval from the Claim Summary (Page 0) and only when all of the pages in the claim are error free.

```
Desired ACTION (View/Appr/Next/Jump/Quit): N//A

=========================================================================
Fatal ERRORS Exist. A Bill cannot be Generated until it is Resolved!
=========================================================================

Enter ERROR/WARNING NUMBER for CORRECTIVE ACTION (if desired):
```

Figure 4-12: Error Notice during Claim Approvals

After the user selects the Approval Action and if no claim errors exist, a summary of the charges will be submitted as the bill is presented, followed by a prompt asking if the claim should be approved.

```
                      ***** UB-92 CHARGE SUMMARY *****
                                          Revn              Total
         Description                      Code    Units     Charges
-------------------------------------------------------------------------
ROOM-BOARD/SEMI             | 260.00      120        9     2,340.00
PHARMACY                    |             250                 46.77
EMERG ROOM                  |             450                 50.00
                                                          --------
TOTAL CHARGES                               001             2,436.77

                   ***** HCFA-1500B CHARGE SUMMARY *****
   Dates of    Vst   CPT      Description       Corr
   Service     Typ   Code     of Service        ICD     Charge      Qty  Cat
-------------------------------------------------------------------------
 10-01-1990     IH   49520   REREPAIR INGUINAL   750.6     975.00    1     2
                             HERNIA
 10-01-1990     IH   90070   OFFICE/OP VISIT,              104.00    2     1
                             EST, EXTEND
                                                         ---------
                                                        1,073.00

                            Previous                                  Bill
      Form         Charges     Payments    Write Offs  Non-cvd      Amount
      -------      -------     -------     ------      -------      -------
      UB-92        2,436.77    1,728.09      139.93       0.00       568.75
      HCFA-1500B   1,073.00      321.91       26.07       0.00       725.02
                  =========   =========   =========   ========    ========
                   3,776.77    2,050.00      166.00       0.00      1293.77

Do You Wish to APPROVE this Claim for Billing? YES

Transferring Data. . . .
            Bill Number 1E Created.  (Export Mode: UB-92)
            Bill Number 1F Created.  (Export Mode: HCFA-1500)
```

Figure 4-13: Approval Summary Screen

If the user approves the claim, one or more bills are created (depending upon whether multiple forms have been specified). After the claim is approved, it is closed to further editing until a payment is posted on the bill or the bill is canceled. If using the BAR package, the claim is closed to further editing until the bill is rolled back to ABM from the BAR system. The created bills are put in a status awaiting export (printing).

For bills being sent to Medicare, the professional component can be suppressed if a contract provider was the attending or operating provider and the patient has Part B coverage.

```
                        ***** UB-92 CHARGE SUMMARY *****
                                  Revn                    Total       Non-cvd
          Description             Code    Units          Charges      Charges
-------------------------------------------------------------------------------
ALL INCL R&B/ANC                400.00    100    14     5,600.00     1,200.00
                                                        --------
TOTAL CHARGES                                    001    5,600.00

NOTE: The Professional Component (HCFA-1500) can be suppressed because a
      Contract Provider is designated as either the attending or operating
      physician.
Do you want to Generate the Professional Component? Y// <RETURN>
```

Figure 4-14: Medicare Inpatient with Contract Provider

The example above illustrates how the covered and non-covered charges will be presented on the UB-92 for flat rate billing.

To contrast the difference between normal flat rate billing and billing Medicare for ambulatory surgery, the following example is provided.

```
***** UB-92 CHARGE SUMMARY *****
                                      Revn                  Total    Non-cvd
Description                            Code     Units     Charges   Charges
-------------------------------------------------------------------------
ALL INCLUSIVE RATE          |49515     519        1        76.00     0.00
                            |15931     519        1         0.00
                                      ------              -------
TOTAL CHARGES                          001                 76.00
```

Figure 4-15: Medicare Ambulatory Surgery

In the example above, the CPT codes have a different charge in the Medicare Ambulatory Fee Schedule because of arrangements made with the Health Care Finance Administration (HCFA). This is the format that IHS is required to use. If you are billing for ambulatory surgery from a locally established Medicaid fee schedule (or other negotiated rate insurer), the charges from the fee schedule will be used.

4.1.8 PAGE 1 - Claim Identifiers

Unless the claim contains errors, the Claim Identifiers page is skipped when using the NEXT command from page 0. The only way to get to this page is by directly jumping to it or by using the BACK command from page 2.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 1 ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DANIELSON,RODNEY  [no HRN]                Claim Number: 1


.......................(CLAIM IDENTIFIERS).........................

                 [1] Clinic.............: OPTOMETRY
                 [2] Visit Type.........: OUTPATIENT
                 |3| Bill Type ……….....: 131
                 [4] Billing From Date..: 10/01/1990
                 [5] Billing Thru Date..: 10/12/1990
                 |6| Super Bill Number……:
                 |7| Mode of Export…….....: HCFA-1500-E

Desired ACTION (Edit/View/Next/Jump/Back/Quit): N//
```

Figure 4-16: Claim Identifiers Screen (Page 1)

To edit a field on page 1, select the EDIT command and designate the field(s) to be altered.

View Action
Using the VIEW command on this page displays information about the patient, his or her employer, and the facility where the visit occurred.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 1  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DANIELSON,RODNEY  [no HRN]                   Claim Number: 1
................. (IDENTIFIER - VIEW OPTION) ......................

Patient.: DANIELSON,RODNEY (no HRN)   Sex.: M    DOB..: 01-23-1957
            200 HOPALONG WAY            Home Phone......: 262-7711
            NOSCHITI, NM  32432         Marital Status..: MARRIED

 Employer...: INDIAN HEALTH SERVICE     Empl. Status..: FULL-TIME
                2433 FIRST ST           Work Phone....:
                TUCSON, AZ  24354
-------------------------------------------------------------------
Facility: ALBUQUERQUE HOSPITAL             Tax Number..: 234832423
          C/O ALBUQUERQUE ADMINISTRATION   Phone.......: 8-766-3569
          505 Marquette NW, Ste 1502
          Albuquerque, NM  87102
-------------------------------------------------------------------

Enter ERROR/WARNING NUMBER for CORRECTIVE ACTION (if Desired):
```

Figure 4-17: View Action, Page 1

If an error or warning condition exists, the user will be notified onscreen and will be given instructions on how to correct the problem.

4.1.9 PAGE 2 - Billing Entities

This page displays the patient's current billable resources, allows the user to select the entity to bill, and displays the active mode of billing.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 2 ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DANIELSON,RODNEY  [no HRN]                    Claim Number: 1
.............................(INSURERS).............................

To:   BLUE CROSS OF CALIFORNIA         Bill Type...: 111
      PO BOX 70000                     Proc. Code..: CPT4
      VAN NUYS, CA  91470              Export Mode.: UB-92
      (818)-703-3413                   Flat Rate...: N/A
.....................................................................

          BILLING ENTITY              STATUS       POLICY HOLDER
      ======================       ==========  ====================
[1]  BLUE CROSS OF CALIFORNIA   ACTIVE      JOO,EUN
[2]  MEDICARE                   PENDING     DANIELSON,TOM
[3]  MONTANA MEDICAID           PENDING     DANIELSON,TOM
---------------------------------------------------------------------
WARNING:005 - INSURER ASSIGNED PROVIDER NUMBER UNSPECIFIED
---------------------------------------------------------------------

Desired ACTION (Pick/View/Next/Jump/Back/Quit): N//
```

Figure 4-18: Billing Entities Edit Screen (Page 2)

The Insurer page is separated into two sections. The first section displays demographic information about the active billing entity and the mode of billing as defined for that entity in the Insurer file. The second section shows a listing of all billable resources for the patient and his or her current billing status and policyholder.

Only one entity can be billed at a time. Selecting the entity to bill is the billing clerk's responsibility. The sequence in which the entities are initially presented is determined by the most common hierarchical order for coordination of benefits. The Claim Generator will attempt to present accident insurance as primary if the visit was marked "accident-related" in PCC and the relationship to policyholder was flagged as "accident/tort-related" in Patient Registration.

The billing mode corresponds to the entity setup in the Insurer file (under Table Management). To change how an insurer is billed, make the necessary modifications to the insurer's record. For more information on setting up the insurers billing mode, refer to the Add/Edit Insurer option (section 8.6.1).

```
......................... (INSURERS) ..............................

To: IHS MEDICARE - NM BC/BS         Bill Type...: 111
PO BOX 13597                        Proc. Code..: ICD9
ALBUQUERUQE, NM  87112              Export Mode.: UB-92
                                    Flat Rate...: 400.00
.....................................................................
```

Figure 4-19: Billing Mode for Inpatient Medicare

In the example above, the hospital services will to be billed at a flat rate of $400.00 on a UB-92, and the procedures will be coded in an ICD format.

Pick Action
The PICK command allows the user to select the insurer to bill.

```
Desired ACTION (Pick/View/Next/Jump/Back/Quit): N//P

Sequence Number of Payer to BILL:  (1-3): 2

BLUE CROSS OF CALIFORNIA is Currently the Billing Source!

Do you wish to bill NEW MEXICO MEDICAID? YES
```

Figure 4-20: Page 2 - Pick Action

Picking an insurer to bill makes it the active billing entity, changes the billing mode to correspond accordingly, and changes the status of all other insurers to pending.

ADD and DELETE Commands
The ADD and DELETE commands are available only when the Accident or Employment Related fields are set to yes on the Questions page (Page 3). These commands enable the user to change the billable entities in the claim so that an insurer other than the patient's third party resources can be billed (i.e., Workers' Compensation).

VIEW Command
The VIEW command can be used to obtain information about the active insurer, policy, or policyholder.

```
Desired ACTION (Pick/view/Next/Jump/Back/Quit):  N// V
Sequence Number to VIEW:  (1-3):  1
```

Figure 4-21: Page 2 - VIEW Command

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 2  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: LUCERO,DONNA JD  [HRN:5824]                      Claim Number: 635
.......................... (INSURER - VIEW OPTION) ..........................

Insurer..: PRINCIPAL FINANCIAL                Phone....: (800)826-1820
Prov. No.:                                    Contact..:
-------------------------------------------------------------------------------
Policy Number....: 505923582                  Coverage(s).....:
Group Name.......: SELF                       Group Number....: 2398743
   Elig date.....: JAN 01, 1994                Elig end date..:
-------------------------------------------------------------------------------
Policy Holder.: LUCERO,DONNA JD                  Relationship..: SELF
                3873 ALAMEDA BLVD NE             Home Phone....: 505 655 5623
                ALBUQUERQUE, NM  87364

   Employer...: PRESBYTERIAN HEALTH PLAN         Empl. Status..: FULL-TIME
                PO BOX 27845                     Work Phone....:
                ALBUQUERQUE, NM  87125
-------------------------------------------------------------------------------

 Enter ERROR/WARNING NUMBER for CORRECTIVE ACTION (if Desired):
```

Figure 4-22: Page 2 - VIEW Command Example

4.1.10 PAGE 3 - Questions

The Questions page enables the user to include additional miscellaneous billing information so that it can be exported to the billing entities. It is not required that all or any of these questions be answered. The set of questions that will appear is dependent on the established mode of export.

The following list contains all questions that may be asked and an example of how a subset would be displayed for editing.

1. "Release of Information..:"
2. "Assignment of Benefits..:"
3. "Accident Related..:"
4. "Employment Related..:"
5. "Emergency Room Required..:"
6. "Special Program..:"
7. "Outside Lab Charges..:"
8. "Blood Furnished (pints).."
9. "Date of First Symptom..:"
10. "Date of Similar Symptom..:"
11. "Date of First Consultation..:"
12. "Referring Physician..:"
13. "Revenue Code/Charge..:"
14. "Case No. (External ID)..:"
15. "Medicaid Resubmission Number..:"
16. "Radiographs Enclosed..:"
17. "Orthodontic Related..:"

18. "Init Prosthesis Placed..:"
19. "Prior Authorization No...:"
20. “HCFA-1500B Block 19 …..:”
21. “Type of Admission ……..:”
22. “Source of Admission …….:”
23. “Patient Status ……:”

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3  ~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DANIELSON,RODNEY  [no HRN]                 Claim Number: 1
.......................... (QUESTIONS) ............................

[1]  Release of Information..: YES From: 01/01/1990 Thru:
[2]  Assignment of Benefits..: YES From: 05/02/1990 Thru:5/02/1991
[3]  Accident Related........: NO
[4]  Employment Related......: YES
[5]  Emergency Room Required.: YES   $50.00
[6]  Special Program.........: NO
[7]  Outside Lab Charges.....: NO
[8]  Blood Furnished.(pints).: NO
[9]  Date of First Symptom...:
[10] Date of Similar Symptom.:
[11] Date of 1st Consultation:
[12] Referring Physician.....:
[13] Revenue Code/Charge.....: 274  $422.00

Desired ACTION (Edit/Next/View/Jump/Back/Quit): N// <RETURN>
```

Figure 4-23: Page 3, Questions Screen

The only fields that have an error or warning condition associated with them are the Release Of Information and Assignment Of Benefits fields. If the visit type for the claim is anything other than inpatient, the Release of Information and Assignment of Benefits prompts will correspond to entries in the Patient Registration System. In the example above, the registration information is listed as a visit date range.

> **NOTE:** Editing these fields will update the registration information and all existing and subsequent non-inpatient claims for that patient.

If the claim is created automatically from PCC data, some of the questions may be already answered (i.e., Accident, Employment Related, Emergency Room Utilized, Special Program).

If the patient’s file indicates that the visit was accident- or employment-related (in the Accident Related or Employment Related fields), the Billing Entities page will allow you to add or delete insurers. Under these conditions it may be desirable to bill an entity (i.e., Workers’ Compensation) other than the patient’s third party resources.

If an entry is specified in the Outside Lab Charges field and the affiliation of the Billing Facility is 638, the unit charge amount on the CPT Laboratory Page (8E) will be editable. It

is the user's responsibility to ensure that the charges entered on the Laboratory page equate to the outside lab charge entered on this page.

The Revenue Code/Charge field can be used to present a special charge (supplies, equipment, ambulance, etc.), to be included in the bill. When billing Medicare for Intraocular Lenses during an Ambulatory Surgery visit, the Revenue Code 274 should be entered along with the corresponding invoice amount of the IOL.

Answering questions on this page can also automatically trigger entries in other pages.

If the Emergency Room Utilized field is set to yes and if itemized fee schedule billing is in effect, the final bill will contain a $50.00 emergency room charge.

If the Emergency Room Utilized field is set to yes and if the export mode is on a UB-92, Page 9C will contain the appropriate Condition Code.

If the Emergency Room Utilized field is set to yes, the Admission Type and Admission Source fields on Page 7 will be set to Emergency and Emergency Room, respectively.

If the Accident Related field is set to yes and if the export mode is in a UB-92 format, page 9A will contain the appropriate Occurrence Code.

If the Employment Related field is set to yes and if the export mode is on a UB-92, page 9C will contain the appropriate Condition Code.

If the Special Program field is set to yes and if the export mode is on a UB-92, page 9E will contain the designated Special Program.

4.1.11 PAGE 4 - Providers

The Providers page enables the user to designate the attending and operating providers and display the providers' numbers and disciplines.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 4  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DANIELSON,RODNEY  [no HRN]                    Claim Number: 1
.............................. (PROVIDER DATA) ...................

             PROVIDER            NUMBER     DISCIPLINE
        =====================  ==========  ========================
(attn)  MEDICAL,DOCTOR         NM-877687   PHYSICIAN
(oper)  WELBY,MARCUS           MI-299834   PHYSICIAN

Desired ACTION (Add/Del/View/Next/Jump/Back/Quit): N// <RETURN>
```

Figure 4-24: Provider Screen

To designate the attending or operating provider a selection must be made from the Provider File. Presently, the ABM system does not allow for more than one attending provider or more than one operating provider.

If the claim was generated automatically from PCC data, the providers will already be established. The Primary Provider in PCC is typically the attending provider.

If no entries exist on the Medical Services Page (8A), a minimal level of service entry will automatically be triggered when a physician is added as the attending provider and the visit type is not inpatient or dental.

Adding A Provider
The Add Command allows for adding the attending and operating providers.

```
Desired ACTION (Add/Del/View/Next/Jump/Back/Quit): N//A

Select Provider: WELBY,MARCUS

     Select one of the following:

          A         Attending
          O         Operating
          R         Other

Provider Status: O// <RETURN> Operating
```

Figure 4-25: Adding a Provider

To add a provider, select the ADD command and select the appropriate provider. You can select a provider by entering the provider's name or initials. At the "Provider Status:" prompt, indicate the provider's status (attending, operating, or other).

The claim system will not allow the user to designate more than one attending or one operating provider, but does allow for the operating and attending provider to be the same.

Viewing Provider Information
The VIEW command on the Providers page displays information about the attending and operating providers and lists all providers entered through PCC.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 4  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DANIELSON,RODNEY  [no HRN]                    Claim Number: 1
....................... (PROVIDER VIEW OPTION) .......................

Attn Prov..: MEDICAL,DOCTOR                        Phone #....:
Discipline.: PHYSICIAN                             Licensure #: NM-877687
Affiliation: TRIBAL                                DEA #......: ZA7733774

Oper Prov..: MARCUS,WELBY                          Phone #....:
Discipline.: PHYSICIAN                             Licensure #: MI-399232
Affiliation: IHS                                   DEA #......:
------------------------------------------------------------------------
             ***** Provider Information Entered Through PCC *****
PRI        PROVIDER                                 DISCIPLINE
=== ================================   ============================
 P  GIVER,GREAT CARE                   PHYSICIAN
 S  MARCUS,WELBY                       PHYSICIAN
------------------------------------------------------------------------
```

Figure 4-26: Provider VIEW Command

The provider number assignment follows to the following criteria:

1. If the Payer Assigned Provider Number has been entered for the provider, it will be used.

2. If the billing entity is Medicare and a Medicare number has been entered for the Provider, it will be used. If there is no Medicare number but a UPIN number has been entered, then that will be used. If there is no Medicare or UPIN number entered, then a default of PHS000 will be used.

3. If the billing entity is Medicaid and a Medicaid number has been entered for the provider, it will be used. If there is no Medicaid number entered, then the claim editor will display error number 170 (Medicare/Medicaid Provider Number Unspecified for Providers).

4. If the provider has a state license for the state where the visit occurred, the state license number will be used. This number is located in the provider file.

5. The UPIN number from the provider file will be used if no state license number has been entered.

For Medicare Part B Only:

The provider number entered into the insurer file will display on the claim as long as the insurer is Medicare and the visit type is 999 (Professional Component).

4.1.12 PAGE 5A - Diagnosis Data

The Diagnosis page enables the user to select and manipulate the visit diagnosis information. This page displays the hierarchical sequence number, the ICD code, its description, and the provider's narrative for each diagnosis.

Displaying both the ICD description and the provider's narrative provides the user a means to ensure data entry accuracy through comparison. The user can control whether the page presents a short or long version of the ICD description by editing the Site Parameters file.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 5A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DANIELSON,RODNEY  [HRN:1121]                 Claim Number: 5
.............................. (DIAGNOSIS) ........................

BIL   ICD9
SEQ   CODE  - Dx DESCRIPTION              PROVIDER'S NARRATIVE
===  ============================    ==================================
 1   366.04 - NUCLEAR NONSENILE         NUCLEAR CATARACT
 2   550.02 - BILATERAL INGUINAL        BILAT INGUINAL HERNIA W/ GANG
                   HERNIA WITH GANGRENE

Desired ACTION (Add/Del/Edit/Seq/View/Next/Jump/Back/Quit): N// <RETURN>
```

Figure 4-27: Diagnosis Screen

If the claim is created from PCC data, the diagnosis and corresponding provider's narrative will already be entered in the order designated by the provider.

The provider's narrative will be presented on the bill and should be comprehensible to an outside entity (internal abbreviations removed, etc.).

> **NOTE:** Altering data in the claim system that was obtained from PCC will not impact the original PCC data.

Adding a Diagnosis

To add a diagnosis to the claim, the user must make a selection from the ICD Diagnosis file. Diagnoses are selected from the file using a lookup program that finds entries based on words, independent of order or punctuation, contained in the diagnostic narrative. Keywords established for the ICD Diagnosis file that are partially matched by words in the input narrative are considered a lookup hit by which abbreviated words can contribute to the search. A listing of keywords using during ICD lookups can be obtained from the facility's PCC data entry operator.

```
Desired ACTION (Add/Del/Edit/Seq/View/Next/Jump/Back/Quit): N// A

=======================  ADD MODE - DIAGNOSIS  =======================
Select Diagnosis: BILAT INGUINAL HERNIA GANGRENE
( BILAT/BILATERAL GANGRENE HERNIA/HERNIATED/HERNIATION INGUINAL/INGUINALE).....

The following matches were found:

   1: 550.02 (BILAT ING HERNIA W GANG)
       BILATERAL INGUINAL HERNIA, WITH GANGRENE

   2: 550.03 (RECUR BIL ING HERN-GANG)
       RECURRENT BILATERAL INGUINAL HERNIA, WITH GANGRENE

   3: 550.12 (BILAT ING HERNIA W OBST)
       BILATERAL INGUINAL HERNIA, WITH OBSTRUCTION, WITHOUT MENTION
       GANGRENE

Select 1-3: 1

Select PROVIDER NARRATIVE: BILAT ING HERNIA W GANG// BILATERAL INGUINAL HERNIA
WITH GANGRENE

 =-=-=-= The Diagnosis has been Added. =-=-=-=
```

Figure 4-28: Adding a Diagnosis

NOTE: In the above example, the default value for the Provider's Narrative was the short version of the ICD narrative. If it is inconsistent with the Provider's Narrative or unclear, it should be altered accordingly.

Deleting A Diagnosis

The DELETE command can be used to delete diagnosis data by specifying the sequence number of the diagnosis to be removed.

```
Desired ACTION (Add/Del/Edit/Seq/View/Next/Jump/Back/Quit): N//D1

Do you wish 550.01 DELETED? YES
```

Figure 4-29: Deleting a Diagnosis

As a safeguard measure the user will be prompted if the ICD Code entry is to be deleted prior to the system removing the entry specified.

Viewing Additional Diagnosis Information

The VIEW command for the Diagnosis page will display the PCC diagnosis information for the visit, including the cause of injury and modifiers (if the claim was automatically created from PCC data).

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 5A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DANIELSON,RODNEY  [no HRN]                    Claim Number: 1
....................... (DIAGNOSIS VIEW OPTION) ..................

             ***** DIAGNOSIS INFORMATION ENTERED THROUGH PCC *****
PRI ICD CD        PROVIDER'S NARRATIVE                CAUSE OF INJURY
=== ====== ====================================  ======================
 P  366.9  CATARACTS BOTH EYES
```

Figure 4-30: Diagnosis View Action

If PCC data entry activity occurs after the claim has been edited, the claim will not be automatically updated. Instead, the system will display a warning that PCC data entry activity occurred, advising the user to investigate the visit. In this situation, the VIEW command is a useful tool for determining what changes have occurred to the PCC data.

Diagnosis Re-Sequencing

The SEQUENCE Command enables the user to alter the order that the diagnosis will be presented in during export. This function is useful for Diagnostic Related Group (DRG) billing when the diagnosis order influences the rate of collection.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 5A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DANIELSON,RODNEY  [no HRN]                    Claim Number: 1
.............................. (DIAGNOSIS) ........................

BIL   ICD9
SEQ   CODE  - Dx DESCRIPTION              PROVIDER'S NARRATIVE
===  ============================   ================================
 1   366.9  - UNSPECIFIED CATARACT      CATARACTS BOTH EYES
 2   310.0  - FRONTAL LOBE SYNDROME     FRONTAL LOBE DISORDERS

Desired ACTION (Add/Del/Edit/Seq/View/Next/Jump/Back/Quit): N//S

          If you need to change the current billing order then
          enter the sequence numbers above in the desired order
          separated by commas.

          NOTE: If the billing sequence is different from that notated
                in the file then the Physician's Attestation is required!

Enter the desired billing sequence: 1,2//2,1
```

Figure 4-31: Re-sequencing Diagnosis

Note: If the diagnosis sequence is altered to maximize billing, an attestation signed by the provider that coincides with the claim must be on file in the patient's chart.

4.1.13 PAGE 5B - ICD Procedure Data

The ICD Procedure page allows for collection and manipulation of the procedure data in an ICD format.

The page is only accessible when the Procedure Coding Method is ICD.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 5B  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DANIELSON,RODNEY  [no HRN]                    Claim Number: 1
.......................... (ICD PROCEDURES) ..........................

BIL SERV    ICD0
SEQ DATE    CODE - PROCEDURE DESCRIPTION   PROVIDER'S NARRATIVE
=== =====  ============================  ============================
 1  10/02  13.19 - OTHER INTRACAPSULAR          CATARACT REPAIR
             EXTRACTION OF LENS
 2  10/01  53.00 - UNILATERAL REPAIR OF         REREPAIR INGUINAL HERNIA
             INGUINAL HERNIA, NOT OTHERWISE
             SPECIFIED
------------------------------------------------------------------------
WARNING:157 - PROCEDURE(S) ENTERED THAT REQUIRE PRIOR APPROVAL
BY THE INSURER
------------------------------------------------------------------------

Desired ACTION (Add/Del/Edit/Seq/View/Next/Jump/Back/Quit): N// <RETURN>
```

Figure 4-32: ICD Procedure Screen

All of the functions described for the Diagnosis page (section 4.1.12) also apply to the ICD Procedure page. For the sake of brevity, the examples and explanations of the Diagnosis Page will not be repeated. Please refer to section 4.1.12 for more information about using the ADD, DELETE, SEQUENCE, and VIEW commands.

4.1.14 PAGE 6 - Dental Data

The Dental page allows for selection and manipulation of the dental information for the visit. As shown in the following example, the page displays the date of service, ADA code and code description, operative site, surface information, and billing amount for the item.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 6  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DANIELSON,RODNEY  [HRN:132123]                 Claim Number: 7
......................... (DENTAL SERVICES) .........................

      VISIT                                              OPER
      DATE          DENTAL SERVICE                       SITE SURF   CHARGE
      =====  ========================================  ==== =====  ======
[1]  03/15/97  1205 TOPICAL FLUORIDE WITH PROPHY-ADULT              32.00
[2]  03/15/97  2120 AMALGAM-TWO SURFACE DECIDUOUS                   33.00
                                                                    =====
                                                                   $65.00

------------------------------------------------------------------------ ERROR:133
- DENTAL OPERATIVE SITE NOT SPECIFIED
WARNING:134 - DENTAL SURFACE NOT SPECIFIED
------------------------------------------------------------------------
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit): N// A
```

Figure 4-33: Dental Screen

If the claim was automatically created by the Dental package, all dental information should have already been entered. Dental procedures use American Dental Association (ADA) codes and specify tooth and surface information.

As shown in the example in Figure 4-33, if a dental service is tooth-specific and the operative site or surface data is missing, an error or warning message will be displayed on the screen.

Adding A Dental Service
Use the ADD command to add a dental procedure.

1. Type A or ADD at the "Desired Action:" prompt on the Dental page.
2. Type the ADA code you wish to add at the "Select ADA Code:" prompt.
3. Type the date of service at the "Date of Service:" prompt.
4. If applicable, type the name(s) of the operative site and surface at the "Operative Site:" and "Surface:" prompts, respectively.

```
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit): N// A
Select ADA CODE: 2940          FILLING (SEDATIVE)

DATE OF SERVICE: 06/15/1993//   (JUN 15, 1993)

OPERATIVE SITE: 20D  DECIDUOUS SECOND MOLAR,MAND LEFT     K    20D

SURFACE: DB

                     DIAGNOSES
       Seq   ICD9
       Num   Code              Diagnosis Description
       ===  ======   ==========================================
        1   V72.2    DENTAL EXAMINATION
UNITS: 1//
CHARGE: 40//
```

Figure 4-34: Dental Add Mode

There is no keyword lookup utility associated with the Dental file and it is easiest to select/ add dental codes by typing the desired ADA code(s) at the "Select ADA Codes:" prompt. A narrative search, although possible, is typically unsuccessful. Dental Codes can only be selected if they have a corresponding entry in the active Dental Fee Schedule.

The date of service must be entered in the standard FileMan date format.

The "Operative Site:" and "Surface:" prompts will only appear if the dental procedure is tooth-specific. To assign an operative site for the claim, you must select one from the Operative Site file. You can find an operative site in the system by entering a narrative description, the tooth number, or the operative site code itself.

Your response to the "Surface:" prompt must be a one-to-five character combination of the letters O,M,D,B,L,F, and I.

4.1.15 PAGE 7 - Inpatient Data

The Inpatient Data page enables the user to enter hospitalization information for a claim.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 7 ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: KERR,SARAH  [no HRN]                        Claim Number: 1
.............................(INPATIENT DATA).........................

[1] Admission Date...: 06-01-1990       [2] Admission Hour....: 14
[3] Admission Type...: 04 (NEWBORN)     [3a] Newborn Days.....:  5
[4] Admission Source.: 01 (NORMAL BIRTH)
[5] Admitting Diag...: 235.3 (NEOPLASM OF UNCERTAIN BEHAVIOR OF LIVER AND BILIA)

[6] Discharge Date...: 06-07-1990       [7] Discharge Hour....: 12
[8] Discharge Status.: 01 (DISCHARGE TO HOME)
[9] Service From Date: 06-01-1990       [10] Service Thru Date: 06-07-1990
[11] Covered Days...: 6                 [12] Non-Cvd Days...: 1
[13] Auth Number.....: SA889123

Desired ACTION (Edit/Next/View/Jump/Back/Quit): N//
```

Figure 4-35: Inpatient Screen

When a claim is created, the majority of the Inpatient page fields are automatically completed. The hospital code fields will be saved to reflect whatever is the most normal condition, unless the claim contains PCC data that indicates otherwise.

If you add or edit data on this page and no entries exist on the Medical Services page, the level of service entries will automatically be established for the day of admission, each subsequent inpatient day, and the day of discharge.

Editing Admission Type

The Admission Type, Newborn Days, and Admission/ Newborn Code fields have a relationship that is contingent upon what you enter at the "Admission Type:" prompt.

```
Desired ACTION (Edit/Next/View/Jump/Back/Quit): N// E3

[3] Admission Type.........: 01// <RETURN> NEWBORN
[3a] Newborn Days..........: 4
[4] Admission/Newborn Code..: NORMAL BIRTH
```

Figure 4-36: Designating Admission Type as Newborn

If you set the Admission Type to Newborn (01), the "Newborn Days:" prompt will appear and require an entry. The "Admission/Newborn Code:" prompt will appear and require a newborn code. If the field already contains an admission code, the existing code will be deleted and you will be prompted for a newborn code. In addition, a nursery room entry

and a delivery room entry will be added to the Accommodations page. The nursery room entry will be equal to the number of newborn days entered at the "Newborn Days:" prompt.

If the admission type is designated as anything other than Newborn (01), the "Newborn Days:" prompt will not appear and the "Admission/Newborn Code:" prompt will require an admission code. If the field already contains a newborn code, the existing code will be deleted and you will be prompted for a new entry. In addition, no delivery room or nursery room entries will appear on the Accommodations page.

Newborn Days And Flat Rate Billing
If newborn days are designated on the claim and the billing mode is flat rate, an additional charge for the newborn will be added to the bill. The example in Figure 4-37 illustrates how this additional charge would appear. In this example, the mother had four inpatient days and the newborn had only three.

```
                ***** UB-92 CHARGE SUMMARY *****
                                 Revn              Total   Non-cvd
         Description             Code     Units   Charges  Charges
-------------------------------------------------------------------
ALL INCLUSIVE RATE      |400.00  100       4     1,600.00   0.00
NURSERY                 |400.00  170       3     1,200.00
                                                 --------
TOTAL CHARGES                    001             2,800.00
```

Figure 4-37: Impact of Newborn Days During Flat Rate Billing

4.1.16 PAGE 8A - Medical Services

The Medical Services page enables the user to collect and manipulate medical data for a specific visit. The CPT codes allowable for use on this page are restricted to those listed in the medicine section of the CPT manual.

> **Note**: The HCFA-1500B allows for up to three modifiers to be appended to the CPT code. If this form (or mode) is indicated, the user will be prompted for multiple modifiers when editing CPT coded entries. This will occur on all appropriate CPT-coded pages.

The professional component entries are screened to prevent data entry error. For example, if the visit type is outpatient, the hospital level service entries are not selectable and vise-versa.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DANIELSON,RODNEY  [HRN:1121]              Claim Number: 5
Mode of Export:  HCFA-1500-E
.......................... (MEDICAL SERVICES) .......................

     REVN                                                  UNIT        TOTAL
     CODE        CPT - MEDICAL SERVICES                  CHARGE QTY  CHARGE
     ====  ========================================    ====== === =======
[1]  CHARGE DATE: 08/26/1990
      960  99211 INITIAL HOSPITAL CARE; BRIEF HISTORY     63.00  1   63.00
                 AND EXAMINATION, INITIATION OF DIAGNOSTIC
                 AND TREATMENT PROGRAMS, AND PREPARATION
                 OF HOSPITAL RECORDS

[2]  CHARGE DATE: 08/26/1990
      960  99231 SUBSEQUENT HOSPITAL CARE, EACH DAY;      23.00  9  207.00
                                                                   --------
                 BRIEF SERVICES                                    $270.00
```

Figure 4-38: Medical Services Screen

If the claim is created using PCC data, the level of service entries will be established as follows accordingly. If the level of service is specified in PCC with a corresponding CPT code, that CPT code will be used. If the level of service is **not** specified in PCC with a corresponding CPT, the following criteria will be used:

- If the visit type is outpatient and the attending or operating provider is a physician, the claim will contain a CPT entry of 99211 (established patient, minimal service).

- If the visit type is inpatient, the following three entries will be created:

    1. CPT code of 99230 (Hospital discharge day management) - one unit

    2. CPT code of 99221 (Initial hospital care, brief) - one unit

    3. CPT code of 99231 (Subsequent hospital care, brief) - units equal to the inpatient days minus two

NOTE: These entries can also be triggered by editing either the Provider or Inpatient pages.

If the automatically established entries are incorrect, the user should be edit or replace them so that the page accurately reflects the medical portion of the visit.

Adding A Medical Service

To add a medical service entry (CPT code) to this page, the user must make a selection from the CPT file. Like the ICD Diagnosis and ICD Procedure files, the CPT entries are selected using the same lookup program. Unlike in the ICD files look-up system, however, keywords (or abbreviations) have not been provided for the CPT file. It is recommended that the local site establish the keywords as appropriate.

```
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N// A

====================  ADD MODE - MEDICAL SERVICES  ====================
Select Medical Service (CPT Code): 92270       ELECTRO-OCULOGRAPHY
       ELECTRO-OCULOGRAPHY WITH INTERPRETATION AND REPORT
         ...OK? Yes//   (Yes)

Select 1st MODIFIER: 24   UNRELATED EVALUATION AND MANAGEMENT SERVICE BY THE
SAME PHYSICIAN DURING A POSTOPERATIVE PERIOD

Select 2nd MODIFIER:

                    DIAGNOSES
       Seq   ICD9
       Num   Code              Diagnosis Description
       ===  ======   ==========================================
        1   550.02   BILAT ING HERNIA W GANG
        2   348.4    COMPRESSION OF BRAIN
        3   571.3    ALCOHOL LIVER DAMAGE NOS

Enter Principle Corresponding DX: 2  348.4   2
Enter Other Corresponding DX (carriage return when done):

   MEDICAL PROCEDURE DATE/TIME field: 06/01/1990//   (JUN 01, 1990)
   MEDICAL PROCEDURE UNITS field: 1//

 =-=-=-= The Medical Service (CPT Code) has been Added. =-=-=-=
```

Figure 4-39: Medical Service Add Mode

The modifier prompts enable the user to include information about abnormal service circumstances in the file. The modifiers that can be selected through this page correspond to those specified as usable in the medicine section of the CPT manual and may influence the amount billed for a specified item. For example, if modifier 52 (Reduced Services) is selected, the user is prompted for the reduced charge. Only one modifier is allowed per service unless the mode of export for this page is HCFA-1500. In this case, the user may enter up to three (3) modifiers for each service.

If the mode of export is HCFA-1500 for page 8A, a corresponding diagnosis must be associated with every service. The user is allowed to choose any existing diagnosis for the visit. If the proper diagnosis is not available through this page, it may be entered on page 5A.

The "Medical Procedure Date/Time" prompt defaults to the visit date. In the example above, the visit date is 06/01/1990. The user can accept the default by pressing the Return key or enter a different date and time after the two slashes (//).

The "Medical Procedure Units field" prompt defaults to the value 1. The user can accept this value by pressing the Return key or enter a different number of units after the two slashes (//).

4.1.17 PAGE 8B - Surgical Procedures

The user can specify the surgical procedures performed during the patient's visit on the Surgical page. The CPT codes allowed for use on this page are restricted to those listed in the surgical section of the CPT manual.

If a HCFA-1500 is to be used for export, this page will also prompt the user for the corresponding diagnosis for each procedure (required). In all other export scenarios, descriptions of the CPT Codes will be displayed instead of a "Corresponding Diagnosis:" prompt. The user will also be prompted for the provider number if the system requires it.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8B  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: JACKSON,RONALD F  [HRN:44362]              Claim Number: 43522
Mode of Export: HCFA-1500B
.............................. (SURGICAL PROCEDURES) ........................

BIL  SERV     REVN   CORR   CPT
SEQ  DATE     CODE   DIAG   CODE           PROVIDER'S NARRATIVE           CHARGE
=== =====     ====   ====  ========= ================================  ========
1  03/31/1997  ***    2,1   61490     INCISE SKULL FOR SURGERY          4,375.00
2  03/31/1997  ***    2     42650-22  DILATION OF SALIVARY DUCT           182.00
                                                                        ========
                                                                       4,557.00

------------------------------------------------------------------------------
WARNING:171 - CPT CODE IS A STARRED (*) PROCEDURE (42650)
------------------------------------------------------------------------------
Desired ACTION (Add/Del/Edit/Seq/View/Next/Jump/Back/Quit/Mode): N//
```

Figure 4-40: Surgical Procedures Screen

If this page is displayed, the procedure information was entered by CPT code. The user may choose to code procedures using the CPT or the ICD method. If the user chose the ICD procedure coding method, page 5B will contain procedure information and this page will not appear.

If a procedure is marked with an asterisk in the CPT manual, a warning message will appear on the screen and alert the user to follow the rules that govern the billing of these procedures. The rules for billing this type of procedure can be found in the CPT manual.

When the insurer requires that the provider number be displayed on the HCFA, the 24K Block option must have *MD* entered for that visit type through the Table Maintenance option.

Adding Surgical Procedures

To add a surgical procedure, the user must first make a selection from the CPT file. CPT procedures are selected using the same keyword lookup utility that was used on page 5a to select a diagnosis. Unlike in the ICD files look-up system, however, keywords (or abbreviations) have not been provided for the CPT file. It is recommended that the local site establish the keywords as appropriate.

Note: Only CPT codes that have a corresponding entry in the current fee schedule may be selected.

```
Desired ACTION (Add/Del/Edit/Seq/View/Next/Jump/Back/Quit/Mode): N// A

===============  ADD MODE - SURGICAL PROCEDURES  ===============
Select Surgical (CPT Code): 61490       INCISE SKULL FOR SURGERY
       CRANIOTOMY FOR LOBOTOMY, INCLUDING CINGULOTOMY
         ...OK? Yes//   (Yes)

Select 1st MODIFIER:
Select PROVIDER NARRATIVE: INCISE SKULL FOR SURGERY//

                     DIAGNOSES
       Seq   ICD9
       Num   Code               Diagnosis Description
       ===  ======   ==========================================
        1   431.     INTRACEREBRAL HEMORRHAGE
        2   471.0    POLYP OF NASAL CAVITY

Enter Principle Corresponding DX: 1  431.   1
Enter Other Corresponding DX (carriage return when done):

   Surgical Procedure DATE/TIME: 03/31/1994//   (MAR 31, 1994)
   Surgical Procedure UNITS: 1//

 =-=-=-= The Surgical (CPT Code) has been Added. =-=-=-=
```

Figure 4-41: Surgical Procedure Add Mode

The modifier prompts enable the user to include information about abnormal service circumstances in the file. The modifiers you can select are restricted to those specified as usable in the surgical section of the CPT manual.

> **Note**: The HCFA-1500B allows for up to three modifiers to be appended to the CPT code. If this form (or mode) is indicated, the user will be prompted for multiple modifiers when editing CPT coded entries. This will occur on all appropriate CPT-coded pages. If the form is anything other than the HCFA-1500B, you will be allowed only one modifier per CPT code.

The following modifiers, when used on this page, will alter the fee schedule amount by the factor indicated below:

Code	Description	Factor
50	BILATERAL PROCEDURE	?
51	MULTIPLE PROCEDURES	?
52	REDUCED SERVICES	?
54	SURGICAL CARE ONLY	0.70
55	PREOPERATIVE MANAGEMENT ONLY	0.10
62	TWO SURGEONS	1.25
80	ASSISTANT SURGEON	0.20
81	MINIMUM ASSISTANT SURGEON	0.10
82	ASSISTANT SURGEON (WHEN QUALIF	0.20

The question marks in the table above indicate that the modifier could affect the charge for a procedure, but that the modified charge is based on a formula and is maintained by the sites.

If modifier number 52 (Reduced Services) is selected, the user is can to reduce the charge of a procedure to a desired amount.

The text contained in the Provider's Narrative field will be presented on the bill and, if necessary, should be altered so that it is comprehensible to an outside entity.

The "Corresponding Diagnosis:" prompt only appears when a HCFA-1500 is to be exported. The field allows for selection of an ICD code restricted to whatever is currently entered in the Diagnosis page.

The "Date Of Service:" prompt will default to the encounter date value. Like all prompts with defaults, this value can and should be overwritten if it is inaccurate.

The "Number of Units:" prompt will default to a value of 1. If more than one unit is used, this value should be overwritten with the correct value.

If the attending or operating provider is a contract provider, the "Do you want a zero charge for this procedure (Y/N)?" prompt will appear when the user is adding an entry (Figure 4-42). If the user types Yes at this prompt, the charge for the procedure will be zero instead of the corresponding charge in the fee schedule.

```
Either the Attending or Operating Provider's affiliation is Contract, depending
upon local policy, procedures done by a Contract provider may be unbillable.

Do you want a Zero Charge for this Procedure   (Y/N)?
```

Figure 4-42: Procedures Performed by a Contract Provider

Surgical Page VIEW Command

The VIEW command for the Surgical Page will display the procedure information for the PCC visit from which the claim was created.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8B  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DANIELSON,RODNEY  [no HRN]                    Claim Number: 1
..................... (PROCEDURE VIEW OPTION) .......................

        ***** PROCEDURE INFORMATION ENTERED THROUGH PCC *****
VISIT         ICD0
DATE   PRI    CODE - PROCEDURE DESCRIPTION         PROVIDER'S NARRATIVE
=====  ===  ================================  ==========================
09/28   S   13.19  INTRACAPSUL LENS EXT NEC  CATARACT REPAIR
-------------------------------------------------------------------------
WARNING:163 - NO CORRESPONDING CPT CODE FOR AN ICD PROCEDURE ENTERED
THRU PCC
-------------------------------------------------------------------------

Enter ERROR/WARNING NUMBER for CORRECTIVE ACTION (if Desired):
```

Figure 4-43: Viewing Additional Surgical Information

If PCC data entry activity occurs after the claim has been edited, the claim will not be updated automatically. Instead, a warning will appear advising the user that PCC data entry activity occurred and that the visit should be investigated. In this situation, the VIEW command is a useful tool for determining what changes have occurred to the PCC data.

4.1.18 PAGE 8C – Revenue Code

The revenue code enables to user to specify room and board charges and/or other charges related to a revenue code.

```
 ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8C  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: JACKSON,RONALD F  [HRN:44362]                   Claim Number: 43522
Mode of Export: HCFA-1500-E
 ............................. (REVENUE CODE) .............................

                                                                      TOTAL
    REVENUE CODE                              CHARGE    DAYS   UNITS    CHARGE
    ==================================    ======    ====   =====    ========
[1] CHARGE DATE: 08/21/1990
    120 ROOM-BOARD/SEMI                   292.00       4       4     1,168.00

[2] CHARGE DATE: 08/20/1990
    360  OR SERVICES                       303.00       0       2       606.00
                                                     =====          ==========
                                                       4            $1,774.00
-------------------------------------------------------------------------------
WARNING:142 - ACCOMMODATION DAYS DO NOT EQUAL THE APPROVED STAY DAYS
-------------------------------------------------------------------------------
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N//
```

Figure 4-44: Revenue Code Screen

As the example in Figure 4-44 illustrates, an error condition will occur if the value in the Approved Stay Days field does not equal the value in the Days of Stay field. Only certain entries on this page account for Days of Stay; the Nursery, Delivery Room, and Operating Room entries are all unit-oriented but do increment the Days of Stay value.

During claim creation or an edit of the Inpatient Data page, entries are automatically created in the Revenue Code page. An entry of Semi-Private Room & Board will be established with the units equal to the number of covered days.

If the CPT procedures entered indicate childbirth or if newborn days have been specified, a Nursery Room entry will be created with units equal to the number of newborn days and a Delivery Room or an Operating Room entry will be created with a unit of one (1) (depending on whether the CPT codes indicates a Cesarean or normal childbirth).

VIEW Command

The VIEW command on this page displays information from the Inpatient Data page. Its primary purpose is to provide the user with a convenient way of resolving an inconsistency error between the Covered Days field value and the Days of Stay field value.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8C  ~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DANIELSON,RODNEY  [no HRN]                    Claim Number: 1
Mode of Export: HCFA-1500-E
..................... (PAGE 8C - VIEW OPTION) .....................

Admission Date: 10-01-1990               Bill From Date: 10-01-1990
Discharge Date: 10-12-1990               Bill Thru Date: 10-12-1990

          Covered Days..: 11       Non-Cvd Days..: 0
------------------------------------------------------------------------

Enter ERROR/WARNING NUMBER for CORRECTIVE ACTION (if Desired):
```

Figure 4-45: Viewing Additional Room & Board Information

Adding Revenue Codes

Adding a revenue code first requires making a selection from the Revenue Code file. Entries from this file may be found by typing the revenue code or description at the appropriate prompt. Any revenue code can be added through this command.

The Units field is set to a default value of one (1) but should be overwritten if this value is inaccurate.

The Unit Charge field is set to the default value of the charge stored in the Revenue Code file. If this charge is not correct, it should be modified.

```
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N// A
Select REVENUE CODES: 360          OR SERVICES      GENERAL CLASSIFICATION
UNITS: 2
UNIT CHARGE: 303//
DATE/TIME: 08/21/1990
```

Figure 4-46: Adding Revenue Codes

4.1.19 PAGE 8D - Medications

The Medications page enables the user to collect and manipulate the record of drugs dispensed to the patient during the visit. The medications available for selection are restricted to those entries that exist in the Drug file at each site. The Drug file is maintained by the pharmacy and should reflect all locally prescribed take-home drugs.

If the claim was created automatically and the RPMS Pharmacy system is running, all prescribed drugs for the visit will already be entered.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8D ~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DANIELSON,RODNEY  [no HRN]                    Claim Number: 1
Mode of Export: HCFA-1500-E
............................ (MEDICATIONS) ............................

     REVN                                                        TOTAL
     CODE              MEDICATION                          QTY   CHARGE
================================================================================
[1]   CHARGE DATE:  08/26/1990
                       IBUPROFEN 400MG TAB                  25      2.45
[2]  CHARGE DATE:  08/26/1990
     5-4561-23         METHOTREXATE 2.5MG TAB               25      4.68
[3]  CHARGE DATE:  08/26/1990
                       PENICILLIN VK 250MG TAB              20      0.04
[4]  CHARGE DATE:  08/26/1990
                       AMPICILLIN 500MG CAP                 30      2.28
                                                                  ========
                                                                   $ 9.45
```

Figure 4-47: Medications Screen

If the NDC Code (5-4507-23) for a selected drug has been entered in the Drug file, it will be displayed accordingly (Figure 4-47).

Since the Pharmacy System manages the drug costs, it is extremely important that the pharmacists keep the drug cost information up to date so that billing accurately reflects the true costs. In addition to the drug cost on file, a dispense fee will automatically be charged for each drug prescribed.

> **NOTE:** Altering the medication information on this page will not effect the data in the Pharmacy system. Over-the-Counter (OTC) drugs may be entered on this page if the drug exists in the Drug file and the ABM fee table.

Adding Medications

To add a medication to a claim, the user must make a selection from the Drug file by entering the name of the drug at the "Select Drug Generic Name:" prompt.

```
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N// A
Select DRUG GENERIC NAME: PENICILLIN G POTASSIUM  PEN-G POTASSIUM 5MIL.UNIT VIAL
          AM051
Is this entry an IV? NO//
REVENUE CODE: 250//           PHARMACY      GENERAL CLASSIFICATION
DATE/TIME: 03/31/1994//   (MAR 31, 1994)
Units (at $1.075 per unit): 20
Times Dispensed (at $10 per each time dispensed) : 1//

                     DIAGNOSES
       Seq   ICD9
       Num   Code              Diagnosis Description
       ===  ======   ==========================================
        1   431.     INTRACEREBRAL HEMORRHAGE
        2   471.0    POLYP OF NASAL CAVITY

Enter Principle Corresponding DX: 1  431.   1
Enter Other Corresponding DX (carriage return when done):
```

Figure 4-48: Adding Medications

If the encounter visit type is 111 (Inpatient) or 831 (Ambulatory Surgery), the user will be prompted if this drug is an IV. The default value is no, but the user may change it to yes.

The Revenue Code field will have a default value of 260 if the chosen drug is an IV; otherwise, the value will be 250. The user may change the revenue code if the default value is inaccurate.

If this medication is an IV, the user will be prompted for an IV price per unit. A default value will appear but should be overwritten if it is incorrect. A complete example of adding an IV drug to a claim is shown in Figure 4-49.

The following prompts appear only for IV medications (Figure 4-49):

- IV TYPE: Indicate the type of IV used here. Possible values are Piggyback, Admixture, Hyperal, Syringe, or Chemotherapy.
- IV ADDITIVE: Make a selection from the IV Additive file.
- IV SOLUTION: Make a selection from the IV Solution file.
- IV NARRATIVE: Answer with a brief description or notes. Only ten characters are allowed.

The Date/Time field has a default value of the encounter date but should be overwritten if it is incorrect. The Units field does not provide a default value but requires an entry.

For non-IV drugs, the unit charge is automatically obtained from the Drug file and is not editable through the Claim Editor. As mentioned above, the user is allowed to modify the IV Price Per Unit field as needed.

The "Times Dispensed:" prompt has a default value of one (1), but may be changed if it is inaccurate. The dispense fee is automatically obtained from the fee schedule and is not editable through the Claim Editor.

```
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N// A
Select DRUG GENERIC NAME: MAGNESIUM CITRATE SOLN.             GA202
Is this entry an IV? NO// YES
IV Price per Unit:  (0-9999): .95// 100.76
REVENUE CODE: 260//           IV THERAPY      GENERAL CLASSIFICATION
IV TYPE: P  PIGGYBACK
IV ADDITIVE:
IV SOLUTION:
IV NARRATIVE: TEST
DATE/TIME: 03/31/1994//   (MAR 31, 1994)
Units (at $100.76 per unit): 2
Times Dispensed (at $ per each time dispensed) : 1//

                           DIAGNOSES

       Seq   ICD9
       Num   Code               Diagnosis Description
       ===  ======   ============================================
        1   431.     INTRACEREBRAL HEMORRHAGE
        2   471.0    POLYP OF NASAL CAVITY

Enter Principle Corresponding DX: 2  471.0   2
Enter Other Corresponding DX (carriage return when done):
```

Figure 4-49: Adding Medications (IV)

Medications - VIEW Command

The VIEW command on the Medications page displays a list of all drugs prescribed by the pharmacy on the encounter date. If the visit is inpatient, the VIEW command displays a list of all drugs prescribed by the pharmacy between the admission and discharge dates.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8D  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DANIELSON,RODNEY  [HRN:1121]                 Claim Number: 4
Mode of Export: HCFA-1500-E
..................... (MEDICATION VIEW OPTION) .....................

          ***** MEDICATIONS ENTERED THROUGH THE PHARMACY SYSTEM *****

Rx#     Drug                              Qty    Issued    Last Fill  Rem
-------------------------------------------------------------------------
172     AMPICILLIN 500MG CAP               30  09-28-1990  09-28-1990   (1)
          NDC#:
173     PENICILLIN VK 250MG TAB            20  09-28-1990  09-28-1990   (0)
          NDC#:
174     IBUPROFEN 400MG TAB                25  09-28-1990  09-28-1990   (0)
          NDC#:
-------------------------------------------------------------------------

Enter ERROR/WARNING NUMBER for CORRECTIVE ACTION (if Desired):
```

Figure 4-50: Viewing Pharmacy Data

Displaying this data ensures that all drugs prescribed are billed accordingly.

> **Note:** If drugs were prescribed that are **not** contained in the claim, the user must check that those drugs are not involved with a different claim before including them on the current claim.

4.1.20 PAGE 8E - Laboratory Services

The Laboratory page enables the user to specify laboratory tests performed in conjunction with the visit. The entries on this page are designated by CPT code. The allowable CPT codes are restricted to those listed in the laboratory section of the CPT manual. For a CPT code to be selectable, it must also have a corresponding entry in the laboratory section of the current fee schedule.

```
         ~~~~~~~~~~~~~~~~~~~~~~  PAGE 8E  ~~~~~~~~~~~~~~~~~~~~~~~~~
      Patient: DANIELSON,RODNEY  [no HRN]                 Claim Number: 1
      Mode of Export: HCFA-1500-E
    ..................... (LABORATORY SERVICES) .........................

     REVN                                                  UNIT       TOTAL
     CODE         CPT - LABORATORY SERVICES               CHARGE QTY  CHARGE
     ==== ========================================  ====== === ========
[1]  CHARGE DATE: 08/26/1990
      307  81010 URINALYSIS; CONCENTRATION AND DILUTION   13.00  3    39.00
                TEST
[2]  CHARGE DATE: 08/26/1990
      301  82141 AMMONIA; URINE                          23.00  1    23.00
[3]  CHARGE DATE: 08/26/1990
      301  82550 CREATINE PHOSPHOKINASE (CPK), BLOOD;
                TIMED                                   18.00  1    18.00
                KINETIC ULTRAVIOLET METHOD
                                                                  ========
                                                                    $80.00
-------------------------------------------------------------------------------
  ERROR:174 - LABORATORY ACTIVITY IS ASSOCIATED WITH THE PCC VISIT
```

Figure 4-51: Laboratory Page

If the Laboratory system (V 5.2 or higher) is installed and running, the billing system will automatically obtain laboratory information from the RPMS environment. This version will also create orphan labs.

When adding a laboratory test, the Revenue Code default value will fluctuate according to that which has already been assigned for the selected CPT.

The Modifiers field can be used for a laboratory test to identify an unusual circumstance. The modifiers allowed for selection are restricted to those specified as usable in the laboratory section of the CPT manual. A modifier may influence the amount billed for the item it modifies.

The Unit Charge field corresponds to the current fee schedule and cannot be altered through the Claim Editor.

Laboratory Page - VIEW Command
The VIEW command on this page displays the laboratory information entered through PCC. The user will see a warning message stating that laboratory data is associated with the PCC visit from which the claim was created.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8E  ~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DANIELSON,RODNEY  [HRN:1121]               Claim Number:
Mode of Export: HCFA-1500-E
..................... (LABORATORY VIEW OPTION ...................

         ***** LABORATORY TEST INFORMATION ENTERED THROUGH PCC *****
VISIT
DATE             LAB PROCEDURE DESCRIPTION
=====  ========================================================================
10/01     GLUCOSE, OTHER
10/02     URINALYSIS
-------------------------------------------------------------------------------
Enter ERROR/WARNING NUMBER for CORRECTIVE ACTION (if Desired):
```

Figure 4-52: Viewing PCC Laboratory Data

NOTE: The information displayed from PCC includes the lab tests ordered for the visit. This may not correspond to the actual lab tests that were performed. Thus, to accurately bill laboratory procedures, the user should also review the lab activity listed in the patient's chart.

4.1.21 PAGE 8F - Radiology Services

The Radiology page allows the user to specify the radiology tests performed in conjunction with the visit. The entries on this page are designated by CPT code. The allowable CPT codes are restricted to those contained in the radiology section of the CPT manual. For a CPT code to be selectable, it must also have a corresponding entry in the radiology section of the current fee schedule.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8F  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DANIELSON,RODNEY  [no HRN]                    Claim Number: 1
Mode of Export:  UB-92
......................... (RADIOLOGY SERVICES) ........................

     REVN                                                 UNIT       TOTAL
     CODE          CPT - RADIOLOGY SERVICES              CHARGE QTY  CHARGE
     ==== ========================================   ====== === ========
[1]  CHARGE DATE: 08/26/1990
     321  70134 RADIOLOGIC EXAMINATION, INTERNAL
          AUDITORY MEATI, COMPLETE                     89.00  2   178.00
[2]  CHARGE DATE: 08/26/1990
     329  70210 RADIOLOGIC EXAMINATION, SINUSES,       48.00  1    48.00
               PARANASAL, LESS THAN THREE VIEWS                  ========
                                                                 $226.00
```

Figure 4-53: Radiology Screen

Currently, the billing system interfaces with the Radiology system. However, radiology tests entered directly into PCC (using CPT procedure codes) will also be included in the claim.

When adding a radiology test to the patient's file, the Revenue Code field will have a default value that corresponds to the selected CPT. Modifiers can also be added to radiology tests to identify unusual circumstances. Allowable modifiers are listed in the radiology section of the CPT manual. A modifier may influence the billed amount for a radiological test.

The Unit Charge field value corresponds to that in the current fee schedule and cannot be altered through the Claim Editor.

4.1.22 PAGE 8G - Anesthesia Services

The Anesthesia page enables the user to specify the anesthesia services performed in conjunction with the patient's visit. The entries on this page are designated by CPT code. Allowable CPT codes are restricted to those listed in the anesthesia section of the CPT manual.

For a CPT code to be selectable, it must have a corresponding entry in both the anesthesia section of the current fee schedule and on the Surgical Procedures page. Therefore, the Anesthesia page is skipped unless data has been entered on the Surgical Procedures page (8B). The Anesthesia page will also be skipped if the anesthesia services performed have been coded "unbillable" for the specified visit type.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8G  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: JACKSON,RONALD F  [HRN:44362]                    Claim Number: 43522
Mode of Export: HCFA-1500B
............................ (ANESTHESIA SERVICES) ............................

     REVN                                                    BASE     TIME    TOTAL
     CODE          CPT - ANESTHESIA SERVICES                CHARGE   CHARGE   CHARGE
     ==== ========================================== ======== ======== =======
[1]       61490 INCISE SKULL FOR SURGERY                    460.00   233.00  693.00
           Start Date/Time: 16-MAR-1997 11:15 AM
            Stop Date/Time: 16-MAR-1997 12:45 PM
                                                                       =========
                                                                         $693.00

Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N// A
```

Figure 4-54: Anesthesia Services

The anesthesia charge is a sum of the base and time charges. The base charge corresponds to that in the current fee schedule and cannot be altered through the Claim Editor. The time charge is derived from a table that uses the elapsed time of the operation as a parameter. The units are restricted to 1; the user should use the Charge Master page if multiple units are necessary. When the insurer requires the provider number for the HCFA, the user will be prompted for the name or number of the provider.

Currently, the billing system does not automatically obtain anesthesia information from an Anesthesia package in the RPMS environment. However, if the anesthesia data is entered into PCC (using a new mnemonic) it will be included in the claim.

Adding Anesthesia Services

To obtain a list of CPT codes available for use, enter a double question mark (??) at the "Select Anesthesia:" prompt. The list will correspond to the entries on the Surgical Procedures page (8B). If no entries exist on the Surgical Procedures page, no anesthesia services can be added.

```
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N// A

===============  ADD MODE - ANESTHESIA SERVICES  ===============
Select Anesthesia (CPT Code): ??

Choose from:
   42650   DILATION OF SALIVARY DUCT
       DILATION SALIVARY DUCT
   61490   INCISE SKULL FOR SURGERY
       CRANIOTOMY FOR LOBOTOMY, INCLUDING CINGULOTOMY

Select Anesthesia (CPT Code): 61490       INCISE SKULL FOR SURGERY
       CRANIOTOMY FOR LOBOTOMY, INCLUDING CINGULOTOMY
         ...OK? Yes//   (Yes)

Select MODIFIER:

                     DIAGNOSES
       Seq   ICD9
       Num   Code              Diagnosis Description
       ===  ======   ==========================================
        1   431.     INTRACEREBRAL HEMORRHAGE
        2   471.0    POLYP OF NASAL CAVITY

Enter Principle Corresponding DX: 1  431.   1
Enter Other Corresponding DX (carriage return when done):

   Anesthesia REVENUE CODE: 370//
   Anesthesia START DATE/TIME: N  (MAR 19, 1997@10:58)
   Anesthesia STOP DATE/TIME: MAR 19, 1997@12:08  (MAR 19, 1997@12:08)

   Anesthesia OBSTETRICAL?:
```

Figure 4-55: Adding an Anesthesia Entry

Modifiers can be added to an anesthesia service to identify an unusual circumstance. The modifiers allowed for selection correspond to those specified as usable in the anesthesia section of the CPT manual. Modifiers available for selection on this page may or may not influence the amount billed for that item.

If the anticipated mode of export is HCFA-1500, a corresponding diagnosis must be specified for each service selected. If the desired diagnosis is not available as a choice, the user must return to page 5A of the Claim Editor and re-enter it.

The "Revenue Code:" prompt only appears if the mode of export is UB-92 (or UB-92-E) and has a default value of 370. If professional services are to be billed separately, those services identified with a revenue code of 963 (Anesthesiologist, Professional Fee) will be on the Professional Component (HCFA-1500).

For each anesthesia service entered, the user is prompted for a START and STOP DATE/TIME. These fields are used to automatically compute the time charge.

If the service is Obstetric-related, the user should type yes at the "Anesthesia Obstetrical?:" prompt. A yes value in this field will also affect the total charge.

4.1.23 PAGE 8H - Miscellaneous Services

This page enables the user to specify any miscellaneous services that were provided during the patient's visit. The entries on this page are **not** designated by HCFA Common Procedure Coding System (HCPCS) codes and any CPT code is allowed. The user selects a HCPCS code in the same way he or she would select a CPT code.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8H  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DANIELSON,RODNEY  [no HRN]                    Claim Number: 1
Mode of Export:  UB-92
.......................... (MISC. SERVICES) ...........................

     REVN                                              UNIT       TOTAL
     CODE       HCPCS - MISC. SERVICES               CHARGE QTY  CHARGE
     ==== ========================================== ====== === =======

[1]  CHARGE DATE: 08/26/1990
     270  GAUZE PADS, STERILE OR NONSTERILE           0.05  4     0.20
[2]  CHARGE DATE: 08/26/1990
     270  URINARY COLLECTION AND RETENTION SYSTEM,    4.45  1     4.45
          DRAINAGE BAG WITH TUBE
[3]  CHARGE DATE: 08/26/1990
     530  CAST SUPPLIES                              42.00  1    42.00
                                                                =======
                                                               $46.65

Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit): N//
```

Figure 4-56: Miscellaneous Services Screen

4.1.24 PAGE 8I – Inpatient Dental Services

This page enables the user to specify any the dental services performed during an inpatient stay. The entries on this page are designated by ADA codes. The user selects an ADA code in the same way he or she would select a CPT code.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8I  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Patient: JACKSON,RONALD F  [HRN:44362]                  Claim Number: 43522
Mode of Export: ADA-94
.......................... (INPATIENT DENTAL SERVICES) ......................

    VISIT                                                  OPER
    DATE           INPATIENT DENTAL SERVICE                SITE SURF  CHARGE
    =====  ================================================ ==== ===== ======
[1] 03/31  1350 SEALANT (PER TOOTH)                          M      I   24.00
                                                                       =======
                                                                        $24.00

Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N//
```

Figure 4-57: Inpatient Dental Services Screen

When adding entries to this screen, the user must specify a corresponding diagnosis with the other inpatient dental services information (Figure 4-57).

4.1.25 PAGE 8J - Charge Master

The Charge Master page enables for the billing of any goods or services provided during the visit including supplies, CPT procedures, etc. The item must exist in the Charge Master file before it can be entered on the claim. Revenue code, quantity, and total charge are displayed with the item description. This page is intended to be a temporary solution, allowing for the billing of supplies, until a facility level supply package can be developed.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8J  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: JACKSON,RONALD F  [HRN:44362]                    Claim Number: 43522
Mode of Export: UB-92
.............................. (CHARGE MASTER) ..............................

     REVN                                                            TOTAL
     CODE                        ITEM                          QTY   CHARGE
================================================================================
[1]  CHARGE DATE: 03/06/1997
           SYRINGE WITH NEEDLE, STERILE 1CC                     1      4.50
[2]  CHARGE DATE: 03/06/1997
      250   SOME KINDA INJECTABLE                               1     20.00
                                                                      ========
     TOTAL                                                             $24.50
--------------------------------------------------------------------------------
WARNING:121 - PROCEDURE(S) MISSING CORRESPONDING REVENUE CODE(S)
--------------------------------------------------------------------------------

Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N//
```

Figure 4-58: Charge Master Screen

Adding a Charge

To add a charge to the claim, the user must make a selection from the Charge Master file. Charges are selected from the file using a lookup program that finds entries based on item description or Universal Product Code (UPC). If the item does not exist in the Charge Master file, it cannot be added to the claim.

```
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N// A
Select 3P CHARGE MASTER ITEM DESCRIPTION: GAUZE
CHARGE DATE: 03/31/1994// T  (MAR 21, 1997)
QUANTITY: 1// 4
UNIT PRICE: 0// 3.42
REVENUE CODE: 272//           STERILE SUPPLY      STERILE SUPPLIES
HCPCS CODE: A4202//

DIAGNOSES
       Seq   ICD9
       Num   Code              Diagnosis Description
       ===  ======   ==========================================
        1   431.     INTRACEREBRAL HEMORRHAGE
        2   471.0    POLYP OF NASAL CAVITY

Enter Principle Corresponding DX: 1  431.   1
Enter Other Corresponding DX (carriage return when done):

Enter RETURN to Continue:
```

Figure 4-59: Adding Item to Charge Master Page

The user is first prompted to enter the date that the specified item was used. The default value is the visit date.

The "Quantity:" prompt has a default value of one (1). This value can and should be changed if the default value is incorrect.

The "UNIT PRICE:" prompt, the "REVENUE CODE:" prompt, and the "HCPCS CODE:" prompt will default to the values associated with the item in the Charge Master file but may be modified if the default values are inaccurate.

> **Note:** If the price, Revenue Code, or HCPCS code is incorrect, the user should return to the Charge Master file and correct the data there too. If the user is changing the HCPCS code value, he or she is only allowed to change it to a value that exists in the CPT file.

As with the rest of the pages, a corresponding diagnosis is required. The user may choose from those already entered on page 5A.

4.1.26 PAGE 9 - UB-92 Codes

The last section of the Claim Editor is comprised of six pages that allow for the specification of UB-92 codes. Pages for the UB-92 codes are as follows:

9A - Occurrence Codes

9B - Occurrence Span Codes

9C - Condition Codes

9D - Value Codes

9E - Special Program Codes

9F - UB-92 Remarks

If entries are made on any of these pages, the exported UB-92 will reflect the entries accordingly.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 9A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DANIELSON,RODNEY  [no HRN]                      Claim Number: 1
.............................. (OCCURRENCE CODES) ......................

      OCCR
      CODE                 OCCURRENCE DESCRIPTION             DATE
      ====    ==========================================  ==========
 [1]   42     DATE OF DISCHARGE                           10-12-1990

Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit): N//
```

Figure 4-60: Occurrence Codes Screen

The example in Figure 4-60 represents one of the UB-92 pages. The remaining pages (9B-9E) are similar. Answering particular questions on the Questions page (page 3) will automatically trigger the entry of the appropriate UB-92 codes.

4.2 Claim Generator, One Patient (CG1P)

Main Menu → EDTP→ CG1P

When you use the CG1P option, the system will generate claims for new PCC visits for each patient indicated. The process is batched off but, under normal circumstances, should produce a claim within five minutes. If the Claim Generator is not executed nightly, the option may take much longer than five minutes.

Step 1: Type the name of the patient you wish to generate a claim for at the "Select Patient Name:" prompt. If the system finds the patient's information in the RPMS database, the patient's additional information will appear beneath the "Select Patient Name:" prompt.

Step 2: Press the Return key to continue entering names and generating claims or type the up-hat (^) to return to the Add/ Edit Claim menu. If you press the Return key, the "Another Patient:" prompt will appear. If you wish to exit the CG1P option, type N and press the Return key. If you wish to continue generating claims with the CG1P option, type Y and repeat step 1.

```
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         |         THIRD PARTY BILLING SYSTEM - VER 2.5                              |
         +              Claim Generator, One Patient                                 +
         |                          SELLS HOSP                                       |
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         User: MAROFSKY,SANDRA                      4-FEB-2002 11:08 AM

Select PATIENT NAME: BEGAY,NODA      M 01-02-1992 234532418 SE 787897

Claim Generator queued for selected patient.
Enter RETURN to continue or '^' to exit:

Another patient? NO//
```

Figure 4-61: Claim Generation For One Patient

4.3 Edit Claim Data (EDCL)

Main Menu → EDTP→ EDCL

This option allows you to edit the data for one specific claim. To select a claim, enter the claim number or a patient identifier (Name, HRN, SSN, DOB). If you choose to enter a patient identifier and multiple claims exist for the patient, a list of claims associated with that patient will appear on the screen and you will be prompted to select one.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |         THIRD PARTY BILLING SYSTEM - VER 2.5                          |
          +                     Edit Claim Data                                   +
          |                        SELLS HOSP                                     |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: MAROFSKY,SANDRA                    19-FEB-2002 2:22 PM

Select CLAIM or PATIENT: JACKSON
   1    JACKSON,AJA CELISSE          F 02-08-1984 601308304   DC 33952
   2    JACKSON,DONALD M             M 03-08-1952 234717135   SE 112233(I)
                                                               SX 32167(I)
                                                               AH 44362
   3    JACKSON,JAMES CHARLES,JR     M 04-08-1988 423318258   DC 63421
   4    JACKSON,KATERI ALEXA VIGIL   F 07-10-1889 076205153   DC 33930
   5    JACKSON,MARIA                F 02-18-1987 473523028   DC 61952

ENTER '^' TO STOP, OR
CHOOSE 1-5: 2  JACKSON,DONALD M      M 03-08-1952 234717135   SE 112233(I)
                                                               SX 32167(I)
                                                               AH 44362

PATIENT:  JACKSON,DONALD M     M  03/08/1952  234-71-7135  HRN: 112233
==========================================================================

(1)  Claim# 29      06/15/1993   DENTAL                  DENTAL
      SELLS HOSP     LEWIS COUNTY MEDICAL SERVICE Status: In EDIT Mode

(2)  Claim# 20      04/11/1994   DENTAL                  DENTAL
      SELLS HOSP     BC OF WASHINGTON & ALASKA    Status: In EDIT Mode

Select 1 to 2: 2

               ...<< Processing, Claim Error Checks >>...

        ...<< Checking Eligibility Files for Potential Coverage >>...
```

Figure 4-62: Selecting a Claim

Once the system has found the claim you have chosen to edit, page 0 of the file will appear on your screen. For more specific information on editing the information in the file, see section 4.1.

4.4 Claim Editor Loop (LOOP)

Main Menu → EDTP→ LOOP

This option enables the user to loop through and edit a series of claims waiting for approval. You can restrict the number of claims to be selected for viewing and editing by entering exclusion parameters at the "Select one or more of the above exclusion parameters:" prompt. Repeat this process until you are finished applying exclusion parameters and press the Return key at a blank "Select one or more of the above exclusion parameters:" prompt.

```
    +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
    |         THIRD PARTY BILLING SYSTEM - VER 2.5                            |
    +                    Claim Editor Loop                                    +
    |                   ALBUQUERQUE HOSPITAL                                  |
    +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
    User: MAROFSKY,SANDRA                    21-MAR-1997 12:27 PM

   EXCLUSION PARAMETERS Selected for RESTRICTING the CLAIM LOOPING to:
   ==================================================================

     Select one of the following:

          1         BILLING ENTITY
          2         DATE RANGE
          3         VISIT TYPE
          4         CLINIC
          5         PROVIDER
          6         ELIGIBILITY STATUS

Select ONE or MORE of the above EXCLUSION PARAMETERS: 3  VISIT TYPE

Select 3P VISIT TYPE NAME: INPATIENT

   EXCLUSION PARAMETERS Selected for RESTRICTING the CLAIM LOOPING to:
   ==================================================================
   Visit Type.........: INPATIENT

     Select one of the following:

          1         BILLING ENTITY
          2         DATE RANGE
          3         VISIT TYPE
          4         CLINIC
          5         PROVIDER
          6         ELIGIBILITY STATUS

Select ONE or MORE of the above EXCLUSION PARAMETERS:
LOOPING through CLAIMS with a Status of IN EDIT MODE....

               ...<< Processing, Claim Error Checks >>...
        ...<< Checking Eligibility Files for Potential Coverage >>...
```

Figure 4-63: Claim Editor Loop Screen 1

The claim editor pages will be displayed for all **inpatient** claims waiting for approval that match your criteria. Between each claim, you will have the option to continue looping, delete the current claim, or quit (Figure 4-64).

```
Desired ACTION (View/Appr/Next/Jump/Quit): N// q

Select one of the following:

          1         CONTINUE LOOPING
          2         DELETE CLAIM
          3         QUIT

Desired ACTION: 1//   CONTINUE LOOPING
```

Figure 4-64: Claim Editor Loop Screen 2

4.5 Add New Claim (Manual Entry) (NEW)

Main Menu → EDTP→ NEW

Claims can be created automatically through the Claim Generator or manually through the NEW option. To manually create a claim, select the Add New Claim option (NEW) from the Add/Edit Claim menu.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
           +              Add New Claim (Manual Entry)               +
           |                  ALBUQUERQUE HOSPITAL                   |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: CHAPEK,JADE                          8-MAR-2002 4:17 PM


Select PATIENT NAME....: CHAPEK, JADE
 ALEXANDER
                                          F 12-15-1978 321321321       321321
Select CLINIC..........: GENERAL//          01
Select VISIT TYPE......: OUTPATIENT//
Enter ENCOUNTER DATE...:  T  (MAR 08, 2002)

Checking eligibility...

               ...<< Processing, Claim Error Checks >>...

        ...<< Checking Eligibility Files for Potential Coverage >>...
```

Figure 4-65: Add New Claim (Manual Entry) Screen- Verifying Patient Data

Step 1: Type the name of the patient you wish to add the claim for at the "Select Patient Name:" prompt. If the system finds the patient's information in the database, the patient's additional information will appear beneath the "Select Patient Name:" prompt. Verify that you have selected the correct patient and continue to step 2.

Step 2: Type the clinic type code or name that corresponds to the clinic where the patient was seen at the "Select Clinic:" prompt.

Step 3: Type the date of the patient's visit (or the date that the patient was admitted if the visit was inpatient) at the next prompt that appears. This prompt will vary depending on your response to the "Select Clinic:" prompt.

Before a claim is created, the system uses the information you just entered and checks to make sure that the visit you are manually adding does not already exist and that the visit is covered by the patient's third party resources. If the data elements of the visit being entered match the data in an existing claim or if no eligible third party resources are found for the patient, the claim creation is terminated and the user is notified of the condition accordingly (Figure 4-66).

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 0  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: CHAPEK,JADE ALEXANDER  [HRN:321321]              Claim Number: 44859
.............................. (CLAIM SUMMARY) ..............................

_______ Pg-1 (Claim Identifiers) _____________________ Pg-4 (Providers) ___________
Location..: ALBUQUERQ HO                | Attn:
Clinic....: GENERAL                     |
Visit Type: OUTPATIENT                  |
Bill From: 03-08-2002 Thru: 03-08-2002  |
                                        |___________ Pg-5A (Diagnosis) ___________
________ Pg-2 (Billing Entity) _________|
NO COVERAGE FOUND                       |
                                        |
___________ Pg-3 (Questions) ___________|________ Pg-8 (CPT Procedures) _________
Release Info: NO    Assign Benef: NO    |
                                        |
                                        |
________________________________________|_____________________________________
  ERROR:004 - CLAIM HAS NO CHARGES (PROCEDURES OR SERVICES) TO BILL
-------------------------------------------------------------------------------
   NOTE: CANNOT OPEN CLAIM - NO ELIGIBILITY FOUND FOR THIS PATIENT.

Do you wish Claim Number 44859 DELETED (Y/N)?
```

Figure 4-66: Manually Adding a Patient-- Unable to Add

If the visit does not already exist in the system and the patient has third party resources on file, the first page of the Claim Editor screens are displayed and you may begin entering data (Figure 4-67). For more information on editing the information in the file, see section 4.1.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 0  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: JACKSON,DONALD M  [HRN:44362]                    Claim Number: 44860
.............................. (CLAIM SUMMARY) ..............................

_______ Pg-1 (Claim Identifiers) _____________________ Pg-4 (Providers) ____________
Location..: ALBUQUERQ HO                 | Attn:
Clinic....: GENERAL                      |
Visit Type: OUTPATIENT                   |
Bill From: 03-05-2002 Thru: 03-05-2002   |
________ Pg-2 (Billing Entity) _________ |___________ Pg-5A (Diagnosis) ___________
ALLEGHANY CORP GRP              ACTIVE   |
NEW MEXICO CHIP                 PENDING  |
MAIL HANDLERS BENEFIT PLAN      PENDING  |
____________ Pg-3 (Questions) ____________|_________ Pg-8 (CPT Procedures) _________
Release Info: YES   Assign Benef: YES    |
                                         |
                                         |
_________________________________________|_____________________________________
  ERROR:004 - CLAIM HAS NO CHARGES (PROCEDURES OR SERVICES) TO BILL
--------------------------------------------------------------------------------

Desired ACTION (View/Appr/Next/Jump/Quit): N//
```

Figure 4-67: Manually Adding a Patient-- OK to Add

4.6 Rebuild Items from PCC (RBCL)

Main Menu → EDTP→ RBCL

This option enables the user to delete certain pages of the claim and have them rebuilt using only PCC data. This function is helpful if a user accidentally edits the wrong claim. Instead of deleting the changes item by item, the user can delete a single page or series of pages and rebuild them with the correct patient's PCC data.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |         THIRD PARTY BILLING SYSTEM - VER 2.5                        |
          +                  Rebuild Items from PCC                             +
          |                        SELLS HOSP                                   |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: MAROFSKY,SANDRA                    20-FEB-2002 4:20 PM

WARNING this option deletes the data from selected pages (subfiles) of the claim
file. Then it looks to see if the data can be rebuilt from PCC. For some pages,
there is no data in PCC. For some, the data may be missing. The data will only
be rebuilt if the information exists in PCC.

Select 3P CLAIM DATA PATIENT: beckm
   1    BECKMAN,MILLY                  F 12-01-1960 649702735   SE 901882
   2    BECKMAN,PENNY                  F 08-01-1935 027424362   SE 113321
CHOOSE 1-2: 2  BECKMAN,PENNY           F 08-01-1935 027424362   SE 113321
     1           01-27-1997     SELLS HOSP
     2           12-11-1996     SELLS HOSP
     3           05-11-1992     SELLS HOSP
     4           05-13-1992     SELLS HOSP
     5           03-26-1997     SELLS HOSP
CHOOSE 1-5: 5
Do you wish to view PCC visit information before continuing? No// n  NO
                                    13  Insurer  (P-2)
15  APC Visit                       17  Diagnosis  (P-5A)
19  ICD Procedure  (P-5B)           21  Surgical Procedure  (P-8B)
23  Pharmacy  (P-8D)                25  REVENUE CODE  (P-8C)
27  Medical Procedure  (P-8A)       33  Dental  (P-6)
35  Radiology  (P-8F)               37  Laboratory  (P-8E)
39  Anesthesia  (P-8G)              41  Providers  (P-4)
43  Misc. Services  (P-8H)          45  Charge Master  (P-8J)

Enter subfile number or list of subfiles to clean out:  (13-45): 41
Claim Generator queued for selected patient.
Enter RETURN to continue or '^' to exit:
```

Figure 4-68: Rebuild Items from PCC Screen

NOTE: This option is to be used only on claims that already exist.

Step 1: Type the claim number or the patient name at the "Select 3P claim data patient:" prompt. If you enter a claim number, the computer automatically knows which PCC visit to select. If you enter the patient's name, you will also be prompted to specify a visit (claim).

Step 2: Type Y or N at the "Do you wish to view PCC visit information before continuing? No//" prompt. If you type Y, the data will be displayed for your review. When you are finished reviewing the PCC data, continue to step 3.

Step 3: The "Enter subfile number or list of subfiles to clean out:" prompt will appear. Type the number that corresponds to the Claim Editor page that you wish to rebuild. You may enter a single number, a series of numbers separated by commas, or a range of numbers using a hyphen. If you want to rebuild as many pages as possible, type 13-45. The Claim Generator is then queued for that patient and you are returned to the Add/Edit Claim menu.

Warning: If you choose to rebuild the claim data and there is no data for the patient in the PCC files, the information currently in the claim will be lost. If you select a claim dated prior to the back-billing limit, the claim will be deleted, not rebuilt. The system will warn you prior to either of these errors occur and ask you if you wish to continue.

```
      +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
      |         THIRD PARTY BILLING SYSTEM - VER 2.5                            |
      +                  Rebuild Items from PCC                                 +
      |                        SELLS HOSP                                       |
      +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
      User: MAROFSKY,SANDRA                    20-FEB-2002 4:19 PM

WARNING this option deletes the data from selected pages (subfiles) of the
claim file. Then it looks to see if the data can be rebuilt from PCC.
For some pages, there is no data in PCC.  For some, the data may be missing.
The data will only be rebuilt if the information exists in PCC.

Select 3P CLAIM DATA PATIENT:    HUGGINS,WILLIAM JAMES
                                              M 05-01-1950 553228866
The date of this claim is prior to the backbilling limit. As a result items
will not be rebuilt from PCC. If you continue, you can only delete items.

Do you wish to continue? No//   NO
```

Figure 4-69: Rebuild Claim Prior to Back-billing Limit Error Message

5 Claim/ Bill Management Menu (MGTP)

Main Menu → MGTP

The options contained in the Claim/Bill Management menu allow the user to manipulate claims and bills.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5                          |
          +               Claim/Bill Management Menu                               +
          |                  ALBUQUERQUE HOSPITAL                                  |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                          5-MAR-2002 1:45 PM


   CLMG   Cancel Claim
   BIMG   Cancel an Approved Bill
   IQMG   Inquire about an Approved Bill
   MRMG   Merge Claims
   BKMG   Initiate Back Billing Check
   ADMG   Add a new BILL that was Manually Submitted
   AOMG   Export Bills to Area Office Tracking System
   FRMG   Flat Rate Adjustment
   OCMG   Open/Close Claim
   RCCP   Recreate claim from PCC data
   SCMG   Split Claim

Select Claim/Bill Management Menu Option:
```

Figure 5-1: Claim and Bill Management Options

5.1 Cancel Claim (CLMG)

Main Menu → MGTP→ CLMG

When a claim is unbillable or all potential billing has been completed, it should be canceled. Removing unbillable or paid claims from the system will free up computer disk space and eliminate unnecessary entries during claim listings.

Once a claim is canceled, it is **permanently** removed and no further editing or approval of that claim can occur. However, any bills already generated from the claim will remain in the system.

```
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         |         THIRD PARTY BILLING SYSTEM - VER 2.5            |
         +                      Cancel Claim                       +
         |                   ALBUQUERQUE HOSPITAL                  |
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         User: MAROFSKY,SANDRA                   02-MAR-2002 1:48 PM

Select CLAIM or PATIENT: 43499  BECKMAN,MARY
                 Clm:43499  06-14-1993 OUTPATIENT    DENTAL           ALBUQUERQ
HO
                          AMER FEDERATION OF GOV EMPL     In EDIT Mode
Correct Claim? YES//
WARNING: If you cancel this Claim it will be deleted and no further
         Editing or Approvals can occur.

Do you wish Claim Number 43499 DELETED (Y/N)? y  YES

OK, the claim is being deleted...

Claim Number: 43499 has been Deleted!

Select CLAIM or PATIENT:
```

Figure 5-2: Canceling a Claim

Step 1: Type the name of the patient or the claim number at the "Select Claim or Patient:" prompt. When the system finds the claim you have selected, additional claim information will appear on the screen. Review the claim information and continue to step 2.

Step 2: Type Y or N at the "Correct Claim? Yes//" prompt. If you have selected the wrong claim, type N and return to step 1. If you have selected the correct claim, type Y and continue to step 3.

Step 3: Type Y or N at the "Do you wish Claim Number [number] Deleted (Y/N)?" prompt. If you do not wish to delete the claim, type N and return to step 1. If you do wish to delete the claim, type Y and continue to step 4.

Step 4: The system will display its deletion progress on the screen. When the system is finished deleting the claim, the "Select Claim or Patient:" prompt will appear again. If you wish to delete another claim, repeat step 1. If you do not want to delete another claim, press the Return key at this prompt without typing anything and you will be returned to the Claim/ Bill Management menu.

5.2 Cancel an Approved Bill (BIMG)

Main Menu → MGTP→ BIMG

After a bill has been printed and all the errors are found, it can be canceled here, corrected through the Claim Editor, and finally approved again for export.

When a bill is canceled, the claim that it was generated from (if it still exists) will be opened for editing.

```
Select BILL to CANCEL: 109B
             Visit: 04-07-1992 DENTAL        DENTAL    SELLS HOSP
              Bill: WISCONSIN MEDICAID     WI-MCD-DEN     176.00

The following Bills are all associated and can only be
CANCELED in a group manner: 109B,109A

Do you want to CANCEL all of these Bills (Y/N)? YES

     **** Bill Number 109B was ALREADY PRINTED/EXPORTED! ****

Do you wish Bill Number 109B CANCELED (Y/N)? YES

Canceling...

Bill Number: 109B has been Canceled!
Bill Number: 109A has been Canceled!
```

Figure 5-3: Canceling an Approved Bill

Step 1: Type the number of the bill you wish to cancel at the "Select Bill to Cancel:" prompt. The system will display additional information about the bill on the screen. Make sure that you have selected the correct bill and continue to step 2.

> **Note**: If two bills were generated together (hospital bill and professional component), they will also be canceled together. Besides the normal confirmation prompt for ensuring that the bill selected is to be deleted, a second prompt will appear if the bill has already been exported (printed).

Step 2: Type Y or N at the "Do you want to cancel all of these bills (Y/N)?" prompt.

Step 3: Type Y or N at the "Do you wish Bill Number [number] Cancelled (Y/N)?" prompt. This prompt may or may not appear, depending on the bills export/ print status.

> **Note:** Canceling a bill in ABM through this option WILL NOT cancel the bill in the Accounts Receivable system.

5.3 Inquire about an Approved Bill (IQMG)

Main Menu → MGTP→ IQMG

At times, it is necessary to investigate the data values contained in a bill. This option enables the user to view every field in the bill that contains data.

```
================================================================================
BILL NUMBER: 137A                          BILL TYPE: 831
  VISIT LOCATION: ALBUQUERQUE HOSPITAL     BILL STATUS: APPROVED
  PATIENT: DANIELSON,THOMAS                EXPORT MODE: UB-92-E V4
  VISIT TYPE: AMBULATORY SURGERY           ACTIVE INSURER: MEDICARE
  PROCEDURE CODING METHOD: CPT             CLINIC: GENERAL
  APPROVING OFFICIAL: JACKSON,DONALD M     DATE/TIME APPROVED: JAN 17, 1995
  BILL AMOUNT: 6143                        INSURER TYPE: PRIVATE INSURANCE
  GROSS AMOUNT: 6143                       *UNCOLLECTED BALANCE: 0
PAYMENT NUMBER: 1                          PAYMENT DATE: MAR 31, 1995
  AMOUNT: 3123                             WRITE OFF: 3020
  ADMISSION TYPE: 02                       ADMISSION SOURCE/NEWBORN CODE: 02
  DISCHARGE STATUS: 02                     PSRO APPROVAL CODE: 05
  PSRO APPROVED STAY FROM: AUG 23, 1990    PSRO APPROVED STAY THRU: AUG 26, 1990
  PROF COMP DAYS: 5                        ADMITTING DIAGNOSIS: 720.1
  ADMISSION DATE: AUG 23, 1990             ADMISSION HOUR: 14
  DISCHARGE DATE: AUG 27, 1990             DISCHARGE HOUR: 12
  NON-COVERED DAYS: 1                      NUMBER OF OUTPATIENT VISITS: 1
  SERVICE DATE FROM: AUG 23, 1990          SERVICE DATE TO: AUG 27, 1990
  COVERED DAYS: 4                          RELEASE OF INFORMATION: NO
  ASSIGNMENT OF BENEFITS: NO               ACCIDENT TYPE: OTHER ACCIDENT
================================================================================
```

Figure 5-4: Display all Information for a Bill

The Bill Inquiry option is particularly useful for determining why a bill did not print or why it printed in the manner that it did. The above example is only a partial listing if the data fields that will be displayed.

To view a bill, type the patient's name or the bill number at the "Select Bill or Patient:" prompt. If you are selecting the bill by patient name (or other identifier) and there is more than one bill on file for the selected patient, you will be prompted to select a specific bill before any bill data appears on the screen.

5.4 Merge Claims (MRMG)

Main Menu → MGTP→ MRMG

This option enables the user to merge two or more claims into one claim. When the user merges claims, a new claim is created containing information from the merged claims. The user also has the option of deleting the merged claims after examining the newly created claim.

Step 1: Type the claim number for the first claim at the "Enter 1st claim:" prompt. If the system finds a match, additional information from the claim file will appear beneath your entry so that you can verify your selection.

Step 2: Type the claim number for the second claim at the "Enter 2nd claim:" prompt. If the system finds a match, additional information from the claim file will appear beneath your entry so you can verify your selection.

Step 3: Type the claim number for the third claim at the "Enter 3rd claim:" prompt. If the system finds a match, additional information from the claim file will appear beneath your entry so you can verify your selection. Continue to add claims at the prompts until you are finished, then continue to step 4.

Step 4: When you are finished adding claims to the merge, press the Return key at an empty "Enter #th claim:" prompt.

Step 5: Type Y or N at the "Proceed with merge?" prompt. If you type N, you will be returned to the Claim/ Bill Management Menu. If you type Y, the system will merge the selected claims.

Step 6: Type Y or N at the "Proceed to Claim Editor? N//" prompt. If you type Y, you will be able to edit the new claim through the Claim Editor function. If you type N, you will skip editing the new claim and should continue to step 7.

Step 7: Type Y or N at the "Delete claims merged from? N//" prompt. If you type Y, the original claims that you merged will be deleted, leaving only the new merged claim. If you type N, the original claims will not be deleted.

```
     +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
     |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
     +                    Merge Claims                         +
     |                     SELLS HOSP                          |
     +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
User: STARR,ANNETTE R                    5-APR-1998 12:11 PM

Enter 1st claim: 39  DANIELSON,EUN     F 01-01-1963 324342234  SE 132123

Enter 2nd claim: 43948  DANIELSON,EUN  F 01-01-1963 324342234  SE 132123

Enter 3rd claim:
PATIENT: DANIELSON,EUN
   CLAIM #s: 39  43948
2 claims selected.
Proceed with merge? YES
Claim # 43950 created.

Merging selected claims to claim 43950
Claim # 39 merged.
Claim # 43948 merged.

Cross referencing new claim # 43950

Proceed to Claim Editor? N// NO
Delete claims merged from? N// YES
Claim # 39 deleted.
Claim # 43948 deleted.
```

Figure 5-5: Merge Two or More Claims

NOTE: The newly created claim is likely to require editing prior to claim approval.

5.5 Initiate Back Billing Check (BKMG)

Main Menu → MGTP→ BKMG

At the initial implementation of this system, and periodically thereafter, it may be desirable to scan all visits, back to a specific date, to determine if they are billable. This task is accomplished with the Initiate Back Billing Check option.

Step1: Type Y or N at the "Do you wish to run this program (Y/N)? prompt. If you type N, you will be returned to the Claim/Bill Management menu. If you type Y, continue to step 2.

Step 2: Type the date that you wish the system to search back to at the "Check all Visits back to (Date):" prompt. Claims with a date of service before the date you enter will not be reviewed.

Step 3: The system will automatically queue the one-time back billing check to run with the nightly claim generator. Press the Return key or type an up-hat (^) at the "Enter Return ton continue or '^' to exit:" prompt to return to the Claim/ Bill Management menu.

```
      +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
      |         THIRD PARTY BILLING SYSTEM - VER 2.5                          |
      +              Initiate Back Billing Check                              +
      |                  ALBUQUERQUE HOSPITAL                                 |
      +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
      User: MAROFSKY,SANDRA                    24-MAR-1997 4:52 PM

   This program will cause the nightly claim generator to initiate
   a one-time job of checking all visits back to the date specified.

Do you wish to run this program (Y/N)? YES

Check all Visits back to (Date): 12-24-1988// 3-23-97  (MAR 23, 1997)

OK, all visits will be checked back to 03-23-1997 during the nightly
claim generation process.

Enter RETURN to continue or '^' to exit:
```

Figure 5-6: Back Billing Check of Old Visits

NOTE: While sites running the PCC system should only need to run this option during the initial setup of the ABM System, APC sites must manually run this option on a regular basis (weekly is recommended).

5.6 Add a New Bill that was Manually Submitted (ADMG)

Main Menu → MGTP→ ADMG

If a bill was prepared and submitted by a mode separate from the ABM billing system, the accounting information should still be entered into this system so that it can be tracked and

managed accordingly. This option enables the user to manually input the accounting information from these bills into the system.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |         THIRD PARTY BILLING SYSTEM - VER 2.5                          |
          +       Add a new BILL that was Manually Submitted                      +
          |                  ALBUQUERQUE HOSPITAL                                 |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: MAROFSKY,SANDRAA                    24-MAR-1997 5:03 PM

     NOTE: This program should only be utilized when an entry in the
           Accounts Receivable File is needed to reflect a bill that
           was manually prepared and submitted.

Proceed? NO// YES

Patient.........: DEMO,JOHN              M 01-23-1944 444444444   AH 234123
Visit Type......: OUTPATIENT
Clinic..........: OPTOMETRY          18
Serv Date From.: 1/5  (JAN 05, 1997)
Serv Date Thru.: JAN 5,1997//
No. of Visits..: 1//  <RETURN>
Insurer.........: MAILHANDLERS BENEFIT PLAN          MARYLAND      20850
Amount Billed..: 422

File Bill? NO// YES
Bill # 43637 Filed.
```

Figure 5-7: Adding a Bill Manually

When a bill is added by use of this option, its data will be transferred to the Accounts Receivable package, payments can be posted for it, and the data it will used during all system reports.

5.7 Export Bills to Area Office Tracking System (AOMG)

Main Menu → MGTP→ AOMG

Periodically, as directed by the Area office, it may be necessary to transfer the created bills to the Area Office Tracking system. This can be accomplished by use of the Export Bills to Area Office Tracking System option.

Usually this process is manually initiated and controlled, but it can also be scheduled with TaskMan to run on a regular basis without any user interaction.

```
    +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
    |          THIRD PARTY BILLING SYSTEM - VER 2.5                          |
    +     Export Bills to Area Office Tracking System                        +
    |                       SELLS HOSP                                       |
    +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+

Do you wish to rerun a Previous Export? N// <RETURN>

NOTE: This program generates a Transmittal List of the Records Exported.

Generate a Transmittal List of the Records Exported (Y/N)? Y// NO

Generating Private Insurance Claim Export Records:
2       4       6       8       10       12       etc.
```

Figure 5-8: Exporting Bills to Area Office Tracking System

Step 1: Type Y or N at the "Do you wish to rerun a Previous Export? N//" prompt. Type Y if a previous transmission was lost or corrupted and you wish to regenerate it. If you type Y at this prompt, you will also be prompted for the previous export date. If you type N at this prompt, continue to step 2.

Step 2: Type Y or N at the "Generate a Transmittal List of Records Exported (Y/N)? Y//" prompt. Typing Y will generate an optional transmittal list, which must be directed to print on a systems printer and cannot be queued.

> **Note**: The transmittal list is not generated when the process is scheduled to run automatically through TaskMan.

Step 3: A summary of the records to be transmitted is displayed prior to the actual transfer (Figure 5-9). If necessary, you can terminate the process by typing the up-hat character (^) at the "Copy transaction file to:" prompt. Otherwise, type T (tape), C (cartridge), or F (file) at the "Copy transaction file to:" prompt. The selected mode of transfer must correspond to the Area office's requirements.

```
*********************************************************************
*           PRIVATE INSURANCE BILLING CLAIM EXPORT REPORT           *
*                         FOR SELLS HOSP                            *
*                           MAY 1,1992                              *
*********************************************************************

          FACILITY CODE =               000101
          DATE EXPORT CREATED =         MAY 1,1992
          BEGINNING CLAIM DATE =        APR 1,1992
          ENDING CLAIM DATE =           MAY 1,1992
          NUMBER OF CLAIM RECORDS =     151
*********************************************************************

Copy transaction file to  ('^' TO EXIT WITHOUT SAVING)

           [T]ape, [C]artridge, [D]iskette, or [F]ile   F// <RETURN>

Please Standby - Copying Data to UNIX File ABPV000101.261
```

Figure 5-9: Export Summary Report

5.8 Flat Rate Adjustment (FRMG)

Main Menu → MGTP→ FRMG

This option enables the user to update flat rates for a specified insurer and visit type beginning on a specific date. Usually when flat rate changes occur, they are retroactive to a specific date and the claims that have already been billed need to reflect the new charge, as Medicare and Medicaid will reimburse at the new rate. Using this option cancels the bill, re-approves the claim, and creates a new bill to reflect the new flat rate. This option is date-sensitive to accommodate the billing of older accounts.

Step 1: Type the name of the insurer that you wish to adjust a flat rate for at the "Select 3P Insurer:" prompt.

Step 2: Type the visit type that you wish to apply the adjustment to at the "Select Visit Type:" prompt. Type two question marks (??) at the prompt to first view a list of available visit types for the insurer that you selected in step 1.

Step 3: Type the date of service that you wish to start applying the flat rate adjustment to at the "Enter a date:" prompt.

Step 4: The system will ask you to verify the information that you entered in steps 1-3. Type Y or N at the "Proceed? N//" prompt. If you type N, you will be returned to the Claim/Bill Management menu. If you type Y, the system will process any bills that meet the criteria you selected in steps 1-3.

Step 5: Press the Return key at the "Press Return to continue or '^' to exit:" prompt to adjust another flat rate. Type an up-hat (^) to return to the Claim/Bill Management menu.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |         THIRD PARTY BILLING SYSTEM - VER 2.5                              |
        +                   Flat Rate Adjustment                                    +
        |                        SELLS HOSP                                         |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: MAROFSKY,SANDRAA                    25-MAR-1997 10:16 AM

This option will adjust the amount billed field for all claims for the insurer
and visit type you select beginning with the date you select to reflect a new
flat rate.

The bills may then be re-loaded to the A/R system.

Select 3P INSURER:    NEW MEXICO MEDICAID
Select VISIT TYPE:    INPATIENT
Enter a date: T-10

I am going to adjust the amount billed field for all bills with visit date 15-
MAR-1997 or later for insurer NEW MEXICO MEDICAID, visit type 111.

NOTE: The flat rate for this insurer, visit type, and date is $420.

Proceed? NO// YES.....

Finished - 5 bills changed.

Enter RETURN to continue or '^' to exit:
```

Figure 5-10: Adjusting Flat Rates

5.9 Open/ Close Claim (OCMG)

Main Menu → MGTP→ OCMG

This option enables the user to reopen claims in a closed status for editing or close claims that are in an open status.

Opening a Claim

Step 1: Type the patient name that is associated with the claim that you wish to open at the "Select 3P Claim Data Patient:" prompt. If the system finds a match, additional claim information will be displayed on your screen so that you can verify your selection. If more than one claim matches the patient name you entered, you will be asked to select a claim from a list before you can continue to step 2.

Step 2: Type Y or N at the "Re-open Claim?" prompt. If you type N, you will be returned to the Claim/Bill Management menu. If you type Y, the system will reopen the claim and prompt you for the name of another patient.

```
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         |         THIRD PARTY BILLING SYSTEM - VER 2.5                              |
         +                    Open/Close Claim                                       +
         |                  ALBUQUERQUE HOSPITAL                                     |
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         User: MAROFSKY,SANDRA                    25-MAR-1997 10:27 AM

Select 3P CLAIM DATA PATIENT: DEMO,JOHN
                                      M 01-23-1944 444444444  AH 234123

Current Claim Status is: Complete
Re-Open Claim? NO// YES

Claim # 43552 now in Edit Mode.

Select 3P CLAIM DATA PATIENT:
```

Figure 5-11: Open Claim

Closing a Claim

Step 1: Type the patient name that is associated with the claim that you wish to close at the "Select 3P Claim Data Patient:" prompt. If the system finds a match, additional claim information will be displayed on your screen so that you can verify your selection. If more than one claim matches the patient name you entered, you will be asked to select a claim from a list before you can continue to step 2.

Step 2: Type Y or N at the "Change Status to Complete? NO//" prompt. If you type N, you will be returned to the Claim/Bill Management menu. If you type Y, the system will close the claim and prompt you for the name of another patient.

```
         |         THIRD PARTY BILLING SYSTEM - VER 2.5                              |
         +                    Open/Close Claim                                       +
         |                  ALBUQUERQUE HOSPITAL                                     |
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         User: MAROFSKY,SANDRA                    25-MAR-1997 10:27 AM

Select 3P CLAIM DATA PATIENT: DEMO,JOHN
                                      M 01-23-1944 444444444   AH 234123
Current Claim Status is: Edit Mode
Change Status to Complete? NO// YES

Claim # 43552 Now in Status Complete.

Select 3P CLAIM DATA PATIENT:
```

Figure 5-12: Close Claim

5.10 Recreate Claim From PCC Data (RCCP)

This option enables users to recreate claims (with the same claim number) that have been cancelled by the Claim Generator. To use this option, the user must know the visit date for the patient.

NOTE: To regenerate the claim immediately, use the Claim Generator, One Patient option (CG1P) on the Add/Edit Claim menu (EDTP). Be sure to wait a few minutes for the Claim Generator to finish before trying to edit the claim.

Step 1: Type the patient name associated with the claim that you wish to recreate at the "Select Patient Name:" prompt. If more than one patient matches your selection, the system will also ask you to select the correct patient from a list of matches.

Step 2: Type the visit date that you wish to recreate for the selected patient at the "Select VISIT:" prompt.

Step 3: The system will display additional information about the visit you have selected. Type Y or N at the "OK? Yes//" prompt. If you type N, you will be returned to the Claim/Bill Management menu. If you type Y, the system queues the new claims to the claim generator and prompts you for another patient name.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |         THIRD PARTY BILLING SYSTEM - VER 2.34           |
          +              Recreate claim from PCC data               +
          |                       SELLS HOSP                        |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: STARR,ANNETTE R                    6-APR-1998 12:59 PM

Select PATIENT NAME: danielson
   1    DANIELSON,EUN                          F 01-01-1963 324342234    SE 132123
   2    DANIELSON,RODNET                       M 01-23-1957 534582511    SE 1121
CHOOSE 1-2: 1
  DANIELSON,EUN                                F 01-01-1963 324342234    SE 132123
Select VISIT: 8/25/90   AUG 25, 1990
  partial match to:  AUG 25, 1990@14:00         DANIELSON,EUN     SELLS HOSP
 HOSPITALIZATION
         ...OK? Yes//   (Yes)

Claim will be created for this visit the next time the claim generator runs.

Select PATIENT NAME:
```

Figure 5-13: Recreate Claim from PCC Data

5.11 Split Claim (SCMG)

Main Menu → MGTP→ SCMG

This option enables users to split certain pages of one claim off into another, creating two claims. The user also has the option of deleting the section moved to a new claim from the original.

For example, if pharmacy charges must be billed to a separate entity, the user can split off page 8D to the new claim and delete it from the original. Any new claim created this way will have a status of "IN EDIT MODE."

Step 1: Type the claim number or the name of the patient associated with the claim at the "Select Claim or Patient:" prompt. The system will display additional information about the claim match so that you can verify your selection.

Step 2: Type the code associated with the section you wish to separate at the "Move which section(s)?" prompt. The system will present your selection for verification.

Step 3: Type Y or N at the "Delete sections from original claim after move? NO//" prompt. If you type N, the section you selected in step 2 will appear on the newly created claim and on the claim you selected it from. If you type Y, the section you selected in step 2 will ONLY appear on the newly created claim.

Step 4: Press the Return key at the "Enter RETURN to continue or '^' to exit:" prompt to select another claim to split or type an up-hat (^) to return to the Claim/Bill Management menu.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |         THIRD PARTY BILLING SYSTEM - VER 2.5                        |
          +                      Split Claim                                    +
          |                       SELLS HOSP                                    |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: MAROFSKY,SANDRA                    26-FEB-2002 5:08 PM

Select CLAIM or PATIENT:    HUGGINS,WILLIAM JAMES      M 05-01-1950 553228866

     Select one of the following:

          8A        MEDICAL
          8B        SURGICAL
          8C        REVENUE CODE
          8D        RX
          8E        LAB
          8F        RADIOLOGY
          8G        ANESTHESIA
          8H        HCPCS
          8I        INPATIENT DENTAL
          8J        CHARGE MASTER
          8Z        ALL

Move Which Section(s)? : 8D  RX

Selected: 8D

Delete sections from original claim after move? NO//

Claim # 43668 created.

Enter RETURN to continue or '^' to exit:
```

Figure 5-14: Split Claim

NOTE: While the user will be prompted for additional selections, only one new claim will be created. If the answer to the delete option is "YES," all selected sections will be deleted.

Warning: When manually splitting a claim, the new claim will have a creation date of when the claim was split instead of when the original claim was created. This information can be viewed through VA FileMan into the 3P Claim file:

```
CLAIM NUMBER: 20853                       PATIENT: CHAVEZ,HENRIETTA
  ENCOUNTER DATE: SEP 23, 2001            VISIT LOCATION: DULCE HEALTH CENTER
  CLAIM STATUS: In EDIT Mode              NUMBER ERRORS FOUND: 1
  CLINIC: DENTAL                          VISIT TYPE: DENTAL
  ACTIVE INSURER: BCBS OF NEW MEXICO      DATE LAST EDITED: OCT 23, 2001
  BILL TYPE: 131                          MODE OF EXPORT: ADA-94
  DATE CREATED: OCT 23, 2001              SERVICE DATE FROM: SEP 23, 2001
  SERVICE DATE TO: SEP 23, 2001           COVERED DAYS: 1
  RELEASE OF INFORMATION: YES             ASSIGNMENT OF BENEFITS: YES
PCC VISIT: SEP 23, 2001@08:00             VISIT STATUS: PRIMARY
INSURER: BCBS OF NEW MEXICO               PRIORITY ORDER: 1
  STATUS: ACTIVE                          PRIVATE INSURANCE MULTIPLE: 1
DIAGNOSIS: V72.2                          PRIORITY ORDER: 2
  PROVIDER'S NARRATIVE: DENTAL/ORAL HEALTH VISIT
DENTAL (ADA CODE): 0120                   REVENUE CODE: 510
  CORRESPONDING DIAGNOSIS: 1              DATE of SERVICE: SEP 23, 2001
  CHARGE: 23.00                           UNITS: 1
  DATA SOURCE: 05|88253|DEN
PROVIDER: SEWELL,R. PATRICK               TYPE: ATTENDING
```

Figure 5-15: New Creation Date on Manually Split Claim

6 Reports Menu (RPTP)

Main Menu → RPTP

This option enables the user to obtain specific reports from the ABM system.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5                          |
          +                      Reports Menu                                      +
          |                   ALBUQUERQUE HOSPITAL                                 |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                          5-MAR-2002 1:46 PM


   BRRP   Brief (single-line) Claim Listing
   SURP   Summarized (multi-line) Claim Listing
   DERP   Detailed Display of Selective Claims
   PRRP   Employee Productivity Listing
   BLRP   Bills Listing
   STRP   Statistical Billed-Payment Report
   PTRP   Billing Activity for a Specific Patient
   DXRP   Listing of Billed Primary Diagnosis
   PXRP   Listing of Billed Procedures
   CHRP   Charge Master Listing
   PARP   PCC Visit Tracking/Audit
   VPRP   View PCC Visit

Select Reports Menu Option:
```

Figure 6-1: Claim Reports Menu

6.1 Report Restricting Features

Most of the billing reports can be restricted to only those records that meet one or more of the exclusion parameters shown in Figure 6-2.

```
EXCLUSION PARAMETERS Currently in Effect for RESTRICTING the EXPORT to:
=========================================================================
   - Billing Entity.....: MEDICARE
   - Export Dates.......: 03/01/1991  to: 03/31/1991
   - Approving Official.: DANIELSON,RODNEY
   - Provider...........: WELBY,MARCUS
   - Report Type........: EXTENDED LISTING (132 width)

Select one of the following:

      1     BILLING ENTITY
      2     DATE RANGE
      3     APPROVING OFFICIAL
      4     PROVIDER
      5     ELIGIBILITY STATUS
      6     DIAGNOSIS RANGE
      7     CPT RANGE
      8     REPORT TYPE

Select ONE or MORE of the above EXCLUSION PARAMETERS:
```

Figure 6-2: Restricting Report to Designated Exclusion Parameters

The example in Figure 6-2 shows the available exclusion parameters that users can choose from. To restrict the report to specific data elements, the user must loop through the desired exclusion parameters and specify the restrictive values. If the user adds a parameter in error, he or she can remove it by reselecting the erroneous parameter and pressing only the Return key when prompted for the restrictive value. Only those parameters applicable to the requested report will be available for selection.

Exclusion Parameters

The APPROVING OFFICIAL and PROVIDER fields require selections from appropriate lists. Only those records whose approving official or provider (depending on the users' selection) will be included on the report.

> **Note**: If the report selected for printing is a claim report, the APPROVING OFFICIAL parameter option is replaced with a CLAIM STATUS parameter option. The CLAIM STATUS parameter allows the user to restrict the report to claims in a specific mode.

```
Select one of the following:

            1        FLAGGED AS BILLABLE
            2        IN EDIT MODE
            3        BILLED AND UNEDITABLE
            4        COMPLETED ALL BILLING
            5        ALL

Select TYPE of CLAIM STATUS to Display:
```

Figure 6-3: Claim Status

The Flagged as Billable status is assigned to claims that were automatically created and haven't been edited by a billing clerk yet. Once a claim has been edited, it is assigned the In Edit Mode status. After a claim has been approved, it's assigned the Billed and Uneditable status. Finally, when a payment is posted on one of the bills created, and if the user elects not to open the claim for rebilling, the claim is assigned the Completed All Billing status.

The DIAGNOSIS and CPT RANGE fields require specifying the low and high restrictive values. If values are selected for these fields, only those records with a diagnosis or procedure that falls between the high and low values will be included on the report.

The BILLING ENTITY parameter allows the user to designate a specific insurer or an insurer category. Only those records that are assigned to the selected insurer or insurer category will be included on the report.

```
      Select one of the following:

           1        MEDICARE
           2        MEDICAID
           3        PRIVATE INSURANCE
           4        NON-BENEFICIARY PATIENTS
           5        BENEFICIARY PATIENTS
           6        SPECIFIC INSURER
           7        SPECIFIC PATIENT
           8        WORKER'S COMP
           9        PRIVATE AND WORKER'S COMP

Select TYPE of BILLING ENTITY to Display: 3     PRIVATE INSURANCE
```

Figure 6-4: Billing Entity

In the above example, the user has chosen to generate a report restricted to private insurance entities only. If users chose to restrict the report to a specific insurer or a specific patient, they will be prompted to make a selection from the applicable file.

The DATE RANGE parameter allows the user to restrict the report to records that fall within a specified date range for a desired date category.

```
Select one of the following:

      1       Approval Date
      2       Visit Date
      3       Export Date
      4       Payment Date

Select TYPE of DATE Desired:

 ==========Entry of EXPORT DATE Range ==========

Enter STARTING EXPORT DATE for the Report:  3/1
Enter ENDING DATE for the Report:  3/31
```

Figure 6-5: Date Range

The date categories that are selectable will vary depending upon the report. If the report is related to claims (rather than bills), the visit date is the only applicable date parameter. If the report is related to bills, the rest of the applicable date parameters (Figure 6-5) are selectable.

The ELIGIBILITY STATUS parameter allows the user to restrict the report to those claims associated with the selected eligibility status.

```
Select ONE or MORE of the above EXCLUSION PARAMETERS: 5 ELIGIBILITY STATUS

     Select one of the following:

          1         INDIAN BENEFICIARY PATIENTS
          2         NON-BENEFICIARY PATIENTS

Select the PATIENT ELIGIBILITY STATUS: 1  INDIAN BENEFICIARY PATIENTS
```

Figure 6-6: Eligibility Status

The Report Type parameter allows the user to control how the report is sorted or totaled. This parameter is only available on reports that print a listing.

```
Select one of the following:

          1         BRIEF LISTING (80 Width)
          2         EXTENDED LISTING (132 Width)
          3         STATISTICAL SUMMARY ONLY
          4         ITEMIZED COST REPORT

Select TYPE of LISTING to Display:
```

Figure 6-7: Report Type

Note: If the user selects the extended listing (option 2), the report will display more data elements than the brief listing and none of the data will be truncated.

6.2 Device Selection

Every billing report in the system may be printed to any device (e.g., system printer, slave printer, host file, or the terminal).

If FORCED QUEUING has been specified in the Site Parameters file, the job will be queued automatically to run at the time specified by the user.

```
As specified in the 3P Site Parameters file FORCED QUEUEING is in effect!
```

Figure 6-8: Forced Queuing

The user will be prompted the following question when the report to be printed requires a 132-width output and a condensed print entry exists for the selected device.

```
(Report requires an output of 132 width)

Should Output be in CONDENSED PRINT (Y/N)?  Y//
```

Figure 6-9: Condensed Printing

If the user selects Yes at the "Should Output be in condensed print:" prompt, the report will be condensed when printed.

NOTE: Some reports require considerable computer resources and should be queued to run after hours or when access to the computer system is not required. Contact your Site Manager for assistance with queuing.

6.3 Brief (Single-line) Claim Listing (BRRP)

Main Menu → RPTP→ BRRP

This listing is particularly useful for determining the claims that were automatically created and those that have yet to be billed.

The listing may be sorted by VISIT TYPE or CLINIC. The sample report below is sorted by VISIT TYPE. Visit location is determined by the location where the user is currently logged in.

An example of the brief (single-line) vlaim listing is shown in Figure 6-10. This sample report was restricted to claims for visits between 11/01/1996 and 3/25/1997 in edit mode with a private insurance billing entity.

```
================================================================================
BRIEF LISTING of CLAIMS IN EDIT MODE                      MAR 25,1997   Page 1
for PRIVATE INSURANCE with VISIT DATES from 11/01/1996 to 03/25/1997
================================================================================
                                                    Claim      Visit
Patient             HRN     Active Insurer         Number      Date         Clinic
--------------------------------------------------------------------------------

   Visit Location: ALBUQUERQUE HOSPITAL
       Visit Type: INPATIENT
JACKSON,RONALD F  44362   BC OF WASHINGTON&ALASK    43627    03/06/1997  GENERAL
                                                    ------
                                        Subtotal:  1

       Visit Type: OUTPATIENT
BECKMAN,PENNY     153507  ASSOCIATED HEALTH PLANS   43605    12/05/1996 GENERAL
BECKMAN,PENNY     153507  ASSOCIATED HEALTH PLANS   43614    02/20/1997 GENERAL
BECKMAN,PENNY     153507  ASSOCIATED HEALTH PLANS   43616    02/25/1997 GENERAL
BECKMAN,PENNY     153507  ASSOCIATED HEALTH PLANS   43617    02/27/1997 GENERAL
BECKMAN,PENNY     153507  ASSOCIATED HEALTH PLANS   43623    02/26/1997 GENERAL
BECKMAN,PENNY     153507  ASSOCIATED HEALTH PLANS   43624    02/28/1997 GENERAL
BECKMAN,PENNY     153507  ASSOCIATED HEALTH PLANS   43625    03/04/1997 GENERAL
BECKMAN,PENNY     153507  ASSOCIATED HEALTH PLANS   43626    03/06/1997 GENERAL
BECKMAN,PENNY     153507  ASSOCIATED HEALTH PLANS   43628    03/07/1997 GENERAL
BECKMAN,PENNY     153507  ASSOCIATED HEALTH PLANS   43632    03/11/1997 GENERAL
DEMO,JANICE               BC/BS OF MARYLAND INC     43607    12/10/1996 PHARMACY
DEMO,JANICE               BC/BS OF MARYLAND INC     43621    12/05/1996 OTHER
JACKSON,RONALD F  44362   BC OF WASHINGTON & ALAS   43635    03/21/1997 GENERAL
SMITH,LINDA               NEW MEXICO BC/BS INC      43602    12/05/1996 GENERAL
SMITH,LINDA               NEW MEXICO BC/BS INC      43603    12/03/1996 GENERAL
                                                    ------
                                        Subtotal:  15

       Visit Type: AMBULATORY SURGERY
BECKMAN,PENNY     153507  ASSOCIATED HEALTH PLANS   43599    11/26/1996 GENERAL
DEMO,JANICE               BC/BS OF MARYLAND INC     43597    11/25/1996 GENERAL
KERR,SARAH                ALLSTATE INS CO GRP       43633    11/26/1996 GENERAL
                                                    ------
                                        Subtotal:  3
                                                    ======
                                           Total:  19
(REPORT COMPLETE):
```

Figure 6-10: Brief (Single-line) Claim Listing

NOTE: Within each visit type, the patients are listed alphabetically.

6.4 Summarized (Multi-line) Claim Listing (SURP)

Main Menu → RPTP→ SURP

The Summarized Claim listing displays a summary of claims specified. This report displays the visit demographics and all diagnosis, procedures, providers and insurers in a multi-line

format. It is particularly useful for viewing all elements of a visit and determining if the visit is billable. Figure 6-11 is an example of a summarized (multi-line) claim listing.

```
04/02/1991                    SELLS HOSP                  Page: 1
            SUMMARIZED LISTING of CLAIMS IN EDIT MODE
                        for ALL BILLING SOURCES

Patient Name  (HRN)              CLM #      Date of Birth    SSN
=========================================================================
JOHNSON,HENRY  (88884)             2           MAY 4,1944

   Visit      Discharge
    Date       Date        Location              Clinic        Type
-------------------------------------------------------------------------
 02/15/1991                SELLS HOSP            GENERAL     OUTPATIENT

ICD Diagnosis                Procedure Narrative      Provider Class
------------------------    ----------------------    ----------------
DIAB HYPEROSM COMA TYPE I/ID  UNILAT ING HERN REP NOS    PHYSICIAN
                              RADICAL EXCIS SKIN LES

Insurance Company              Coverage Types              Status
-------------------------------------------------------------------
MEDICARE                         PART B                  COMPLETED
```

Figure 6-11: Summarized (Multi-line) Claim Listing

6.5 Detailed Display of Selective Claims (DERP)

Main Menu → RPTP→ DERP

The detail claim display option prints all claim pages (with data) exactly as they appear in the claim editing process.

The detailed listing is useful when the user needs a copy of a claim to resolve a question or problem. Figure 6-12 is an example of the detailed display printout.

```
~~~~~~~~~~~~~~~~~~~~~~  DETAILED CLAIM LISTING  ~~~~~~~~~~~~~~~~~~~~~~
Patient: JACKSON,RONALD F                          Claim Number: 43522
..................... (PAGE 1 - CLAIM IDENTIFIERS) .....................

                 [1] Clinic.............: GENERAL
                 [2] Visit Type.........: INPATIENT
                 [3] Bill Type..........: 111
                 [4] Billing From Date..: 03/31/1994
                 [5] Billing Thru Date..: 04/04/1994
                 [6] Super Bill #.......:
                 [7] Mode of Export.....: UB-92

.......................... (PAGE 2 - INSURERS) ..........................

To: JACKSON,RONALD F                    Bill Type...: 111
    2301 TEST LANE                      Proc. Code..: CPT4
    ALBUQUERQUE, NM  87008              Export Mode.: UB-92
    (505) 271-9999                      Flat Rate...: 0.00
.....................................................................

             BILLING ENTITY             STATUS       POLICY HOLDER
     ============================  ==========  ====================
[1]  BC OF WASHINGTON & ALASKA       BILLED      JACKSON,RONALD F
[2]  NON-BENEFICIARY PATIENT         ACTIVE      JACKSON,RONALD F
[3]  MEDICARE                        PENDING     JACKSON,RONALD F
[4]  NEW MEXICO MEDICAID             PENDING     JACKSON,RONALD F

.......................... (PAGE 3 - QUESTIONS) ..........................

 [1] Release of Information..: Yes
 [2] Assignment of Benefits..: Yes
 [3] Accident Related........: NO
 [4] Employment Related......: NO
 [5] Emergency Room Required.: NO
 [6] Special Program.........: NO
 [7] Outside Lab Charges.....: NO
 [8] Blood Furnished.(pints).: NO
 [9] Date of First Symptom...:
[10] Date of Similar Symptom.:
[11] Referring Physician.....:
[12] Radiographs Enclosed....: NO
[13] Orthodontic Related.....: NO
[14] Init Prosthesis Placed..: NO
[15] Prior Authorization No..:
[16] HCFA-1500B Block 19.....:

Enter RETURN to continue or '^' to exit:

~~~~~~~~~~~~~~~~~~~~~~  DETAILED CLAIM LISTING  ~~~~~~~~~~~~~~~~~~~~~~
Patient: JACKSON,RONALD F                          Claim Number: 43522
......................... (PAGE 4 - PROVIDER DATA) .....................

                PROVIDER              NUMBER              DISCIPLINE
        ==========================  ============  ======================
(attn)  ZHIVAGO,DOCTOR              BIA000        CONTRACT PSYCHIATRIST
```

```
..................... (PAGE 5A - DIAGNOSIS) .....................

BIL   ICD9
SEQ   CODE  - Dx DESCRIPTION                    PROVIDER'S NARRATIVE
===  ================================  ================================
 1   431.    - INTRACEREBRAL             INTRACEREBRAL HEMORRHAGE
               HEMORRHAGE
 2   471.0   - POLYP OF NASAL CAVITY     POLYP OF NASAL CAVITY

..................... (PAGE 7 - INPATIENT DATA) .....................

[1] Admission Date...: 03-31-1994       [2] Admission Hour....: 12
[3] Admission Type...: 02 (URGENT)
[4] Admission Source.: 02 (CLINIC REFERRAL)
[5] Admitting Diag...: 431. (INTRACEREBRAL HEMORRHAGE)
[6] Discharge Date...: 04-04-1994       [7] Discharge Hour....: 12
[8] Discharge Status.: 01 (DISCHARGE TO HOME)
[9] Service From Date: 03-31-1994       [10] Service Thru Date: 04-04-194
[11] Covered Days...: 2                 [12] Non-Cvd Days...: 3
[13] Auth Number.....:
------------------------------------------------------------------------
WARNING:146 - PSRO AUTHORIZATION NUMBER NOT SPECIFIED


~~~~~~~~~~~~~~~~~~~~~~  DETAILED CLAIM LISTING  ~~~~~~~~~~~~~~~~~~~~~~
Patient: JACKSON,RONALD F                          Claim Number: 43522
..................... (PAGE 8A - MEDICAL SERVICES) .....................
     REVN                                              UNIT       TOTAL
     CODE         CPT - MEDICAL SERVICES             CHARGE QTY  CHARGE
     ==== ========================================  ====== === =======
[1]  CHARGE DATE: 03/31/1994
          99221 INITIAL HOSPITAL CARE               131.25  1   131.25
[2]  CHARGE DATE: 03/31/1994
          99231 SUBSEQUENT HOSPITAL CARE             78.75  3   236.25
[3]  CHARGE DATE: 03/31/1994
          99238-52 HOSPITAL DISCHARGE DAY            70.00  1    70.00
                                                                =======
                                                               $437.50
------------------------------------------------------------------------
WARNING:121 - PROCEDURE(S) MISSING CORRESPONDING REVENUE CODE(S)
------------------------------------------------------------------------

~~~~~~~~~~~~~~~~~~~~~~  DETAILED CLAIM LISTING  ~~~~~~~~~~~~~~~~~~~~~~
................... (PAGE 8B - SURGICAL PROCEDURES) ...................

BIL SERV   REVN   CPT        CPT                PROVIDER'S
SEQ DATE   CODE   CODE    DESCRIPTION           NARRATIVE        CHARGE
=== ===== ====== ======================== ====================== ========
 1  03/31  960   61490  INCISE SKULL FOR  INCISE SKULL FOR      4,375.00
                  SURGERY                   SURGERY
 2  03/31  960   42650-22  DILATION OF    DILATION OF SALIVARY    182.00
                  SALIVARY DUCT             DUCT
                                                                ========
                                                              $4,557.00
------------------------------------------------------------------------
WARNING:171 - CPT CODE IS A STARRED (*) PROCEDURE (42650)
```

```
------------------------------------------------------------------------

..................... (PAGE 8C - REVENUE CODE) .....................

                                                                 TOTAL
     REVENUE CODE                        CHARGE    DAYS   UNITS  CHARGE
     ============================        ======    ====   =====  =======
[1]  CHARGE DATE: 03/16/1997
      120 ROOM-BOARD/SEMI                315.00      1      1     315.00
[2]   100 ALL INCL R&B/ANC               736.00      2      2   1,472.00
[3]  CHARGE DATE: 03/16/1997
      360 OR SERVICES                    303.00      0      1     303.00
                                                   =====        =========
                                                     3         $2,090.00
------------------------------------------------------------------------
WARNING:142 - ACCOMMODATION DAYS DO NOT EQUAL THE APPROVED STAY DAYS
------------------------------------------------------------------------


~~~~~~~~~~~~~~~~~~~~~~  DETAILED CLAIM LISTING  ~~~~~~~~~~~~~~~~~~~~~~
Patient: JACKSON,RONALD F                        Claim Number: 43522
..................... (PAGE 8D - MEDICATIONS) .....................

     REVN                                                         TOTAL
     CODE                    MEDICATION                     QTY  CHARGE
========================================================================
[1]  CHARGE DATE: 03/31/1994
      250        37-4401-01  PENICILLAMINE 250MG CAP        20   14.12
[2]  CHARGE DATE: 03/31/1994
      250        536-0122-97  ACETAMINOPHEN 160MG/5ML 120ML  35   23.30
[3]  CHARGE DATE: 03/31/1994
      250        995-0520-95  PEN-G POTASSIUM 5MIL.UNIT VIAL 20   31.50
                                                              ========
     TOTAL                                                      $68.92

................... (PAGE 8E - LABORATORY SERVICES) ...................

     REVN                                          UNIT       TOTAL
     CODE     CPT - LABORATORY SERVICES          CHARGE QTY  CHARGE
     ==== ======================================  ====== === =========
[1]  CHARGE DATE: 03/31/1994
      300 80003 3 CLINICAL CHEMISTRY TESTS         52.50  1    52.50
[2]  CHARGE DATE: 03/31/1994
      300 80012-52 12 CLINICAL CHEMISTRY TESTS     50.00  1    50.00
                                                             =========
                                                             $102.50

..................... (PAGE 8F - RADIOLOGY SERVICES) .....................

     REVN                                          UNIT       TOTAL
     CODE     CPT - RADIOLOGY SERVICES           CHARGE QTY  CHARGE
     ==== ======================================  ====== === =========
[1]  CHARGE DATE: 03/31/1994
          70010 CONTRAST X-RAY OF BRAIN           340.00  1    340.00
                                                           ==========
                                                            $340.00
```

```
------------------------------------------------------------------------
WARNING:121 - PROCEDURE(S) MISSING CORRESPONDING REVENUE CODE(S)
------------------------------------------------------------------------

~~~~~~~~~~~~~~~~~~~~~~  DETAILED CLAIM LISTING  ~~~~~~~~~~~~~~~~~~~~~~
Patient: JACKSON,RONALD F                          Claim Number: 43522
.................. (PAGE 8G - ANESTHESIA SERVICES) ....... ............

     REVN                                            BASE     TIME    TOTAL
     CODE     CPT - ANESTHESIA SERVICES            CHARGE   CHARGE   CHARGE
     ==== ================================== ======== ======== =======
[1]  370  61490 INCISE SKULL FOR SURGERY        460.00   233.00   693.00
           Start Date/Time: 16-MAR-1997 11:15 AM
            Stop Date/Time: 16-MAR-1997 12:45 PM
[2]  370  61490 INCISE SKULL FOR SURGERY        460.00 1,492.00 1,952.00
           Start Date/Time: 19-MAR-1997 11:45 PM
            Stop Date/Time: 20-MAR-1997 7:30 AM
                                                              ==========
                                                              $2,645.00

...................... (PAGE 8H - MISC. SERVICES) ......................

     REVN                                                UNIT       TOTAL
     CODE     HCPCS - MISC. SERVICES                    CHARGE QTY  CHARGE
     ==== ========================================  ====== === =======
[1]  CHARGE DATE: 03/31/1994
          A0010 AMBULANCE SERVICE, BASIC LIF          83.00  1    83.00
                                                             =======
                                                              $83.00
------------------------------------------------------------------------
WARNING:121 - PROCEDURE(S) MISSING CORRESPONDING REVENUE CODE(S)
------------------------------------------------------------------------

................ (PAGE 8I - INPATIENT DENTAL SERVICES) ................

    VISIT                                                OPER
    DATE       INPATIENT DENTAL SERVICE                  SITE SURF CHARGE
    =====  ========================================  ==== ==== ======
[1] 03/31  1350 SEALANT (PER TOOTH)                   M     I   24.00
                                                                ======
                                                                $24.00


~~~~~~~~~~~~~~~~~~~~~~  DETAILED CLAIM LISTING  ~~~~~~~~~~~~~~~~~~~~~~
Patient: JACKSON,RONALD F                          Claim Number: 43522
...................... (PAGE 8J - CHARGE MASTER) ......................

     REVN                                                          TOTAL
     CODE              ITEM                                QTY     CHARGE
==========================================================================
[1]  CHARGE DATE: 03/06/1997
            SYRINGE WITH NEEDLE, STERILE 1CC               1        4.50
[2]  CHARGE DATE: 03/06/1997
      250   SOME KINDA INJECTABLE                          1       20.00
[3]  CHARGE DATE: 03/21/1997
      272   GAUZE                                          4       13.68
```

```
                                                                    ========
     TOTAL                                                            $38.18
-------------------------------------------------------------------------------
WARNING:121 - PROCEDURE(S) MISSING CORRESPONDING REVENUE CODE(S)
-------------------------------------------------------------------------------

..................... (PAGE 9A - OCCURRENCE CODES) .....................

      OCCR
      CODE                 OCCURRENCE DESCRIPTION                  DATE
      ====    ============================================  ========
[1]    42     DATE OF DISCHARGE                            04-04-1994
-------------------------------------------------------------------------------
WARNING:177 - OCCURRENCE CODE IS INCONSISTENT WITH TYPE OF BILL
-------------------------------------------------------------------------------

......................... (PAGE 9F - REMARKS) ........................

                 UB-92 REMARKS
      ========================================
       (48 characters x 4 lines max)
     ------------------------------------------------
[1]  Send Payment to Provider (see Block 1)
[2]  WHAT HAPPENED TO LINE 2
[3]
[4]
     ------------------------------------------------

Enter RETURN to continue or '^' to exit:
```

Figure 6-12: Detail Claim Display

6.6 Employee Productivity Listing (PRRP)

Main Menu → RPTP→ PRRP

The employee productivity listing option produces a productivity report for a particular approving official or for all employees. The exclusion parameter for the approving official is preset to be that of the current logged-in user. If a listing for all employees is desired, select the approving official parameter and then press the Return key at the "Select Approving Official:" prompt.

If the report is for a specific employee, the header will include the employees name and the listing will be totaled by the visit location. Otherwise, the header will indicate that it is for all employees and the report will be totaled by employee.

```
        WARNING: Confidential Patient Information, Privacy Act Applies
================================================================================
PRODUCTIVITY REPORT by MAROFSKY,SANDRA             MAR 25,1997   Page 1
for ALL BILLING SOURCES with APPROVAL DATES from 11/01/1996 to 03/25/1997
================================================================================
                                                    Number of     Amount
Location                Visit Type                    Claims      Billed
--------------------------------------------------------------------------------

SELLS HOSP              INPATIENT                          9     37,929.00
                        DENTAL                             1        365.96
                                                       -----    ----------
                                        Subtotal:         10     38,294.96
                                                       -----    ----------
                                           Total:         10     38,294.96

(REPORT COMPLETE):
```

Figure 6-13: Employee Productivity Listing

6.7 Bills Listing (BLRP)

Main Menu → RPTP→ BLRP

The Bills Listing is broken into four selectable categories. The "Select Type of Report:" prompt will allow the user to select a category. If the user does not specify a report type, the system will automatically default to the All Bills report type.

If the user selects the Unpaid Bills report category, the payment fields are suppressed and the name of the patient is listed. All visit identifiers are displayed in the extended (132-width) version of this report.

```
Select one of the following:

        1  UNPAID BILLS
        2  PAID BILLS
        3  ALL BILLS
        4  INCOMPLETE BILLS

Select TYPE of REPORT: 3//
```

Figure 6-14: Bills Listing

Figure 6-15 is an example of a bills listing. The report in Figure 6-15 is in the All Bills format.

```
================================================================================
LISTING of ALL BILLS for ALL BILLING SOURCES             MAR 26,2002   Page 1
================================================================================
                     Claim           Export        Billed    Date        Paid
     Insurer         Number   HRN    Date          Amount    Paid       Amount
--------------------------------------------------------------------------------
   Visit Location: ALBUQUERQUE HOSPITAL
           Clinic: IMMUNIZATION
ARIZONA MEDICAID     44825   3644                   12.00
                     44827   3644                   15.00
NEW MEXICO BC/BS I   44826   3644                    1.00
                     44828   3644                   15.00
                     ------                      ----------             ----------
     Sub-total:      4                              43.00                   0.00

           Clinic: INTERNAL MEDICINE
MEDICARE             44144C  2739                3,195.00  10/27/2000   8,956.56
                     ------                      ----------             ----------
     Sub-total:      1                            3,195.00               8,956.56

           Clinic: MENTAL HEALTH
AETNA HEALTHCARE P   43811   112696                 534.00
```

Figure 6-15: Listing of All Bills

6.8 Statistical Billed- Payment Report (STRP)

Main Menu → RPTP→ STRP

The STRP option enables the user to print a summary report for all bills, sorted and tallied by facility and visit type. See Figure 6-16 for an example of the Statistical Billed Payment report.

```
================================================================================
STATISTICAL REPORT for ALL BILLING SOURCES          MAR 25,1997   Page 1
================================================================================

   VISIT             NUMBER  UNDUP     BILLED      PAID          UNPAID
   TYPE              VISITS PATIENTS   AMOUNT      AMOUNT        AMOUNT
--------------------------------------------------------------------------------

ALBUQUERQUE HOSPITAL
   INPATIENT           6       4     9,786.44     211.89       9,574.55
   OUTPATIENT          4       4    10,920.65     442.65      10,478.00
   AMBULATORY SURG     1       1     6,143.00   3,123.00       3,020.00
   DENTAL              3       3       182.20      30.00         152.20
                     ------  ------ ----------  ----------    ----------
                       14       8    27,032.29   3,807.54      23,224.75

TOTAL COVERED INPATIENT DAYS  18
(REPORT COMPLETE):
```

Figure 6-16: Statistical Billed-Payment Report

NOTE: The Undup Patients column totals are not the sum of the entries for each visit type, but rather a count of unique patients (i.e., if the same patient had an Optometry visit, and a Dental visit, he would be counted only once in the totals).

6.9 Billing Activity for a Specific Patient (PTRP)

Main Menu → RPTP→ PTRP

This option enables to user to view/print the billing activity for a specific patient. The user has the option of including or excluding bills in a completed status.

```
  WARNING: Confidential Patient Information, Privacy Act Applies
========================================================================
BILLING ACTIVITY of DANIELSON,RODNEY              APR 2,1991     Page 1
for ALL BILLING SOURCES
========================================================================
                 Claim           Export     Billed       Date        Paid
Insurer         Number   HRN      Date       Amount      Paid      Amount
------------------------------------------------------------------------
     Visit Location: ALBUQUERQUE HOSPITAL
         Visit Type: INPATIENT
ALASKA VISION SERVICES IN
                   1B    773322 04/02/1997  12,314.66
                   1C    773322               6,109.00
MEDICARE           1A    773322 03/18/1998   4,400.00   03/24/1998   832.00
                                04/02/1998     152.00
                         ------             ----------                -------
         Total:            3                 22,823.66                 832.00
```

Figure 6-17: Billing Activity for a Specific Patient

6.10 Listing of Billed Primary Diagnosis (DXRP)

Main Menu → RPTP→ DXRP

This option enables the user to print a list of primary diagnoses with the billed amount and percent of the total amount per diagnosis. The report can be restricted to a designated ICD diagnosis range.

```
=====================================================================
BILLED PRIMARY DIAGNOSIS for ALL BILLING SOURCES   APR 2,1991   Page 1
=====================================================================
  ICD9
  Code        Diagnosis Description        Bills      Amount     Percent
+-------+-------------------------------+-------+-----------+-------+
  188.1   MAL NEO BLADDER-DOME                3     22,823.66    60%
  250.21  DIAB HYPEROSM COMA TYPE I/IDDM       1         76.00    20%
  550.02  BILAT ING HERNIA W GANG              1      2,433.00    20%
                                          +======= +============+
Primary Diagnosis Total                        5     25,332.66
                                          +======= +============+
```

Figure 6-18: Billed Primary Diagnosis Listing

6.11 Listing of Billed Procedures (PXRP)

Main Menu → RPTP→ PXRP

The PXRP option enables the user to print a listing of procedures showing the billed amount and percent of the total amount per diagnosis. The user may elect to list procedures for one or for all categories. See Figure 6-20 for an example of this report.

```
     +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
     |         THIRD PARTY BILLING SYSTEM - VER 2.5                    |
     +              Listing of Billed Procedures                       +
     |                  ALBUQUERQUE HOSPITAL                          |
     +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
     User: MAROFSKY,SANDRA                  26-MAR-1997 11:47 AM

   ----- PROCEDURE CATEGORIES -----

    Select one of the following:

         1         MEDICAL
         2         SURGICAL
         3         RADIOLOGY
         4         LABORATORY
         5         ANESTHESIA
         6         DENTAL
         7         ROOM & BOARD
         8         MISCELLANEOUS (HCPCS)
         9         PHARMACY
         10        ALL

   Select Desired CATEGORY: 10  ALL
```

Figure 6-19: Selecting Procedure Category

```
========================================================================
BILLED PROCEDURES for ALL BILLING SOURCES          MAR 26,1997   Page 1
========================================================================
                                                          Amount
 Code        Procedure Description                Count    Billed  Percent
-------+-----------------------------------------+------+---------+-------
 100     ALL INCL R&B/ANC                          1      970.00   3.0%
 120     ROOM-BOARD/SEMI                           3    2,523.00   9.0%
 276     INTR OC LENS                              2      350.00   1.0%
 450     EMERG ROOM                                1      100.00   0.0%
 1515    SPACE MAINT., FIXED BILATERAL             1      345.76   1.0%
 2150    AMALGAM-TWO SURFACE PERMANENT             1       35.00   0.0%
 5200    PARTIAL DENTURE ANY CAST METAL W ACRYLIC  1      315.00   1.0%
 21089   PREPARE FACE/ORAL PROSTHESIS              2      469.30   1.0%
 42426   EXCISE PAROTID GLAND/LESION               3   14,529.00  52.0%
 43251   OPERATIVE UPPER GI ENDOSCOPY              1    1,061.00   3.0%
 66983   REMOVE CATARACT, INSERT LENS              2    4,717.00  16.0%
 72196   MAGNETIC IMAGE, PELVIS                    2    1,121.00   4.0%
 80428   GROWTH HORMONE PANEL                      3      300.00   1.0%
 90724   INFLUENZA IMMUNIZATION                    1       20.00   0.0%
 90726   RABIES IMMUNIZATION                       2       34.00   0.0%
 90727   PLAGUE IMMUNIZATION                       1       18.00   0.0%
 93770   MEASURE VENOUS PRESSURE                   1       17.00   0.0%
 96910   PHOTOCHEMOTHERAPY WITH UV-B               1       20.00   0.0%
 97022   WHIRLPOOL THERAPY                         1       27.00   0.0%
 99211   OFFICE/OUTPATIENT VISIT, EST              1       21.00   0.0%
 99221   INITIAL HOSPITAL CARE                     4      331.00   1.0%
 99231   SUBSEQUENT HOSPITAL CARE                  3      264.00   0.0%
 99238   HOSPITAL DISCHARGE DAY                    3      176.00   0.0%
 0120    ORAL EVALUATION, PERIODIC                 2       47.00   0.0%
 0150    ORAL EVALUATION, COMPREHENSIVE            1       58.00   0.0%
 0274    BITEWINGS, FOUR FILMS                     1       17.50   0.0%
         PRESCRIPTIONS                             7       53.64   0.0%
                                                 +======+=========+=======
                                  Total:           52   27,940.20
                                                 +======+=========+

(REPORT COMPLETE):
```

Figure 6-20: Billed Procedure Listing

6.12 Charge Master Listing (CHRP)

Main Menu → RPTP→ CHRP

The CHRP option enables users to print a summary report for all items in the Charge Master file. It sorts and displays the report based on the criteria selected by the user. The listing can be sorted by one of eight categories, listed in Figure 6-21.

Note: The "Sort by:" prompt will default to Item Description if nothing else is selected.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5                       |
          +                 Charge Master Listing                               +
          |                  ALBUQUERQUE HOSPITAL                               |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         User: GILL,MARILYN                        19-OCT-1998 11:46 AM


SORT BY: ITEM DESCRIPTION// ?  <RETURN>

 Answer with FIELD NUMBER, or LABEL
Choose from:
   .01             ITEM DESCRIPTION
   .02             REVENUE CODE
   .03             HCPCS CODE
   .04             UPC
   .05             OTHER IDENTIFIER
   .06             START DATE
   .07             STOP DATE
   .08             COST CENTER

         TYPE '-' IN FRONT OF NUMERIC-VALUED FIELD TO SORT FROM HI TO LO
         TYPE '+' IN FRONT OF FIELD NAME TO GET SUBTOTALS BY THAT FIELD,
            '#' TO PAGE-FEED ON EACH FIELD VALUE,  '!' TO GET RANKING NUMBER,
            '@' TO SUPPRESS SUB-HEADER,   ']' TO FORCE SAVING SORT TEMPLATE
         TYPE ';TXT' AFTER FREE-TEXT FIELDS TO SORT NUMBERS AS TEXT
         TYPE [TEMPLATE NAME] IN BRACKETS TO SORT BY PREVIOUS SEARCH RESULTS

SORT BY: ITEM DESCRIPTION//
START WITH ITEM DESCRIPTION: FIRST//
DEVICE:     RIGHT MARGIN: 80//
```

Figure 6-21: Charge Master Listing Setup

The example in Figure 6-22 is set to print in the 80-column width format. All identifiers are displayed in the extended (132 width) version of this listing.

```
================================================================================
OCT 19,1998            CHARGE MASTER LISTING                    PAGE  1
================================================================================
ITEM DESCRIPTION             REVENUE CODE   HCPCS CODE     UPC CODE
OTHER IDENTIFIER             START DATE     STOP DATE      COST CENTER
--------------------------------------------------------------------------------
99212
--------------------------------------------------------------------------------
99213
--------------------------------------------------------------------------------
00099                                       00099
    CPT CODE FOR AHCCCS
--------------------------------------------------------------------------------
4X4                          272
--------------------------------------------------------------------------------
BANDAIDS 3 INCH              270            A4460
--------------------------------------------------------------------------------
CRUTCHES, ALUMINUM           450            J0110          0005940004
    123456787
--------------------------------------------------------------------------------
CRUTCHES, WOODEN             273            E0112          43.00
--------------------------------------------------------------------------------
DISKETTES, 3.5 INCH          270                           0005940004
--------------------------------------------------------------------------------
GAUZE                        272            A4202
--------------------------------------------------------------------------------
J1101
--------------------------------------------------------------------------------
LITEPRO 720                  255            A0010          010013100
--------------------------------------------------------------------------------
Leg Splint
  12345 baxter
--------------------------------------------------------------------------------
SOME KINDA INJECTABLE        250            J1200
--------------------------------------------------------------------------------
SURGICAL SCISSORS
--------------------------------------------------------------------------------
SUTURE KIT                   272            A4208
--------------------------------------------------------------------------------
SYRINGE WITH NEEDLE, STERILE 1  272         A4206
--------------------------------------------------------------------------------
SYRINGE WITH NEEDLE, STERILE 2  272         A4207
--------------------------------------------------------------------------------
SYRINGE WITH NEEDLE, STERILE 3  272         A4208
--------------------------------------------------------------------------------
THIS IS A LONG ENTRY TO SEE HO  270
--------------------------------------------------------------------------------
surgical tape
--------------------------------------------------------------------------------
training
```

Figure 6-22: Charge Master Listing Example

6.13 PCC Visit Tracking/ Audit (PARP)

Main Menu → RPTP→ PARP

This report displays the status of a PCC visit in the ABM system. All visits that fall within the user's selected range are displayed with a claim status message attached. The Claim Status column will advise the user if a claim was created in ABM. If a claim was not created, the reason will be displayed. Use this function to determine why a visit exists in PCC but a claim was NOT created in Third Party Billing.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |         THIRD PARTY BILLING SYSTEM - VER 2.5            |
          +                PCC Visit Tracking/Audit                 +
          |                       SELLS HOSP                        |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: MAROFSKY,SANDRAA                  20-FEB-2002 10:19 AM

START WITH VISIT/ADMIT DATE&TIME: FIRST// T-5  (JUN 25, 1997)
GO TO VISIT/ADMIT DATE&TIME: LAST//
DEVICE:     RIGHT MARGIN: 80//
```

Figure 6-23: PCC Visit Tracking/Audit Setup

```
================================================================================
 DATE: 06/30/1997              PCC STATUS REPORT                      PAGE  1
================================================================================
PATIENT NAME            SOC SEC NO     ENCOUNTER LOCATION    HRN  ELIGIBILITY
CLAIM STATUS
--------------------------------------------------------------------------------
         VISIT/ADMIT DATE&TIME: JUN 17,1997  12:00

CARTER,DAVID            772956918      RPMS/CMB              2875 MEDICARE AB
NO DATA FOUND IN FILE #9000010.07 (V POV) FOR THIS VISIT
--------------------------------------------------------------------------------
         VISIT/ADMIT DATE&TIME: JUN 25,1997  12:00

CARTER,DAVID            772956918      RPMS/CMB              2875 MEDICARE AB
CLAIM CREATED
--------------------------------------------------------------------------------
BECKMAN,DIANA           566568365      RPMS/CMB              123321
          NEW YORK MARINE & GENERAL GRP
          ALLIED MUTUAL INS CO GRP
          RAILROAD RETIREMENT B
CLAIM CREATED
--------------------------------------------------------------------------------
```

Figure 6-24: PCC Visit Tracking/Audit Report Example

6.14 View PCC Visit (VPRP)

Main Menu → RPTP→VPRP

This report allows the user to view PCC data from ABM. Once the user has specified a patient by name, the computer will display a list of visits for that patient and the user may choose one to view.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |         THIRD PARTY BILLING SYSTEM - VER 2.5                              |
          +                      View PCC Visit                                       +
          |                        SELLS HOSP                                         |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: MAROFSKY,SANDRA                    20-FEB-2002 11:00 AM

Select PATIENT NAME: DEMO,JOHN               M 01-23-44 444444444   SE 999944

PATIENT: DEMO,JOHN                        SSN: 444-44-4444
         VISIT DATE/TIME      VISIT LOCATION      SERVICE CATEGORY
================================================================================

   (1)   MAR 26, 1997@10:00   SELLS HOSP          AMBULATORY
          Claim Status: EXISTING CLAIM MODIFIED
   (2)   JAN 29, 1993@12:00   ALBUQUERQUE HOSPI   AMBULATORY
          Claim Status: EXISTING CLAIM MODIFIED
   (3)   JAN 26, 1993@12:00   ALBUQUERQUE HOSPI   AMBULATORY
          Claim Status: NO ELIGIBILITY FOUND FOR THIS PATIENT
Enter a number (1-3): 2
Enter Device: HOME//
```

Figure 6-25: View PCC Visit Setup

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

VISIT IEN:  33701
-----------------------------     VISIT FILE     -----------------------------
VISIT/ADMIT DATE&TIME: JAN 29, 1993@12:00
  DATE VISIT CREATED: JAN 29, 1993     TYPE: IHS
  THIRD PARTY BILLED: EXISTING CLAIM MODIFIED
  PATIENT NAME: DEMO,JOHN              LOC. OF ENCOUNTER: ALBUQUERQUE HOSPITAL
  SERVICE CATEGORY: AMBULATORY         CLINIC: GENERAL
  DEPENDENT ENTRY COUNT: 4             DATE LAST MODIFIED: JAN 29, 1993

-----------------------------     V PROVIDER     -----------------------------
PROVIDER: GIVER,OF THE GREATEST CARE   PATIENT NAME: DEMO,JOHN
  VISIT: JAN 29, 1993@12:00            PRIMARY/SECONDARY: PRIMARY
AFF.DISC.CODE (c): 200IJK
PROVIDER: DOLAN,ROBERT F               PATIENT NAME: DEMO,JOHN
  VISIT: JAN 29, 1993@12:00            PRIMARY/SECONDARY: SECONDARY
AFF.DISC.CODE (c): 957123
-----------------------------        V POV       -----------------------------
POV: 112.83                            PATIENT NAME: DEMO,JOHN
  VISIT: JAN 29, 1993@12:00            PROVIDER NARRATIVE: ABSESS L BACK
  MODIFIER: FOLLOW UP                  CAUSE OF DX: HOSPITAL ACQUIRED
  FIRST/REVISIT: REVISIT
ICD NARRATIVE (c): CANDIDAL MENINGITIS
-----------------------------    V MEDICATION    -----------------------------
MEDICATION: ALBUMIN, HUMAN 5% INJ.     PATIENT NAME: DEMO,JOHN
  VISIT: JAN 29, 1993@12:00            SIG: TP
  QUANTITY: 2                          DAYS PRESCRIBED: 60

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

End of visit display, <RETURN> to Continue
```

Figure 6-26: PCC Visit Data Example

7 Print Bills Menu (PRTP)

Main Menu → PRTP

The process of exporting bills includes sending claims to Medicaid, Medicare, and other third party insurers in a format that meets their requirements. The Print Bills menu addresses the needs of printing and managing claim submission to insurers.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5                          |
          +                    Print Bills Menu                                    +
          |                  ALBUQUERQUE HOSPITAL                                  |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                          5-MAR-2002 3:14 PM


   AWPR   Bills Awaiting Export Report
   EXPR   Print Approved Bills
   WSPR   Print Worksheet (Itemized CPT Data)
   MLPR   Print Mailing Address Labels
   REPR   Reprint Bill
   TRPR   Transmittal Listing
   TSPR   Test Forms Alignment

Select Print Bills Menu Option:
```

Figure 7-1: Print Bills Menu

7.1 Selection Of Bills For Processing

7.1.1 Mode Definition

The term *mode* specifies the form to be used when printing. Several insurers may use the same form, and the bills for several insurers may be organized into the same batch. Most firms use the UB-92 and the HCFA-1500 forms (or modes).

7.1.2 Exclusion Parameters

Users may want to group the bills in a batch depending on their location, billing entity, range of dates, approving official, providers, and/or eligibility status. These restrictions, available to the user when selecting bills for processing, are illustrated in the following example.

```
EXCLUSION PARAMETERS CURRENTLY IN EFFECT FOR RESTRICTING THE EXPORT TO:
  ============================================================
   - APPROVING OFFICIAL.: WESLEY,PAUL

     SELECT ONE OF THE FOLLOWING:

          1         LOCATION
          2         BILLING ENTITY
          3         DATE RANGE
          4         APPROVING OFFICIAL
          5         PROVIDER
          6         ELIGIBILITY STATUS

SELECT ONE OR MORE OF THE ABOVE EXCLUSION PARAMETERS:
```

Figure 7-2: Exclusion Parameters

For brevity, the exclusion prompts are displayed here, but are removed from the numerous displays in the following sections of this chapter. Users should know that these exclusion parameters are available for use in many of the Print Bills menu options.

7.2 Bills Awaiting Export Report (AWPR)

Main Menu → PRTP→ AWPR

This option enables users to view and/or print a listing of bills with the Approved claim status. These bills are ready to be sent to the insurer. There are three options available to the user for listing bills that are ready for printing.

```
     +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
     |          THIRD PARTY BILLING SYSTEM - VER 2.5                              |
     +              Bills Awaiting Export Report                                  +
     |                        SELLS HOSP                                          |
     +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
     User: WESLEY,PAUL                          15-APR-1992  1:49 PM

     Select one of the following:

          1         Summarized Report by EXPORT MODE
          2         Summarized Report by INSURER
          3         Listing of UNPRINTED BILLS

Select the desired REPORT TYPE:  1//
```

Figure 7-3: Bills Awaiting Export Report

Summarized Report By Export Mode
The mode specifies the form to be used for printing the bill. Several insurers may use the same form, and because of this, the bills for several insurers may be printed in the same batch. This report allows the user to see how many bills are ready to be sent to insurers by mode.

```
========================================================================
BILLS AWAITING EXPORT FOR ALL BILLING SOURCES       JAN 15,2002   PAGE 1
========================================================================
                                          AVG DAYS
                                NUMBER    AWAITING       TOTAL
   EXPORT MODE                  BILLS      EXPORT       CHARGES
------------------------------------------------------------------------
   HCFA-1500B                      3         45        7,773.95
                                =====                ===========
                                   3                   7,773.95

(REPORT COMPLETE):
```

Figure 7-4: Summarized Report by Export Mode

Summarized Report By Insurer

This report allows the user to see how many bills are ready to be sent to each insurer.

```
========================================================================
BILLS AWAITING EXPORT FOR ALL BILLING SOURCES       JAN 15,2002   PAGE 1
========================================================================
                                       AVG DAYS
                              NUMBER    AWAITING       TOTAL
INSURER                        BILLS     EXPORT       CHARGES
------------------------------------------------------------------------
ALASKA VISION SERVICES INC         2         44        7,674.27
DELTA DENTAL PLAN OF ILLINOIS      1         49           99.68
                                 ===                 =========
                                   3                   7,773.95

(REPORT COMPLETE):
```

Figure 7-5: Summarized Report by Insurer

Listing Of Unprinted Bills

This report displays information on all bills that are ready to be printed. This report is sorted alphabetically by patient name.

```
========================================================================
BILLS AWAITING EXPORT FOR ALL BILLING SOURCES       JUN 15,1992 PAGE 1
========================================================================
BILL                              EXPORT
NUMBER     PATIENT                 MODE           BILLING SOURCE
------------------------------------------------------------------------
115A    BUTLER,TERENCE D        HCFA-1500B   DELTA DENTAL PLAN  ILLINO
19B     DANIELSON,EUN           HCFA-1500B   ALASKA VISION SERVICES INC
 9A     DANIELSON,RODNEY        HCFA-1500-E  ALASKA VISION SERVICES INC

(REPORT COMPLETE):
```

Figure 7-6: Listing Of Unprinted Bills

7.3 Print Approved Bills (EXPR)

Main Menu → PRTP→ EXPR

This option is used to print bills that have been approved and are ready to be sent to an insurer.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |         THIRD PARTY BILLING SYSTEM - VER 2.5                              |
           +                  Print Approved Bills                                     +
           |                       SELLS HOSP                                         |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: MAROFSKY,SANDRA                     2-FEB-2002 12:38 PM


Select the FORM to be EXPORTED: ?
 Answer with 3P EXPORT MODE NUMBER, or FORMAT
Choose from:
   1          UB-82          OMB NO. 0938-0279
   2          HCFA-1500A     Old Version Dated 1-84
   3          HCFA-1500B     New Version Dated 12-90
   4          ADA-90         Dental Claim Form Dated 1990
   11         UB-92          OMB NO. 0938-0279
   12         ADA-94         DENTAL ADA-94 FORM

Select the FORM to be EXPORTED: 3  HCFA-1500B      New Version Dated 12-90

         (NOTE: HCFA-1500B forms should be loaded in the printer.)

Counting...  Number of HCFA-1500B forms awaiting export: 1

Establishing Bills to be Exported for the Parameters Specified...

     Number of HCFA-1500B forms to be Printed: 1

Output DEVICE: HOME//

Printing...
                  (All Print-outs are Complete)

     For Printing Mailing Labels, Worksheets or a Transmittal Listing...
     ...refer to EXPORT BATCH: 19
                 ==========================
                 Number of Records Exported: 1
                 Number of Insurers........: 1
                 Total Amount Billed.......: 2,910.00

Enter RETURN to continue or '^' to exit:
```

Figure 7-7: Print Approved Bills

First, the user is prompted to select the mode (form) to be printed (exported). After selection, the user is reminded to load the specified form in the printer. Then the computer counts the number of approved bills that exist in the system for the specified mode of export and notifies the user.

The computer then evaluates the specified exclusion parameters (omitted in the example to conserve space) and displays a new count of bills ready for printing.

The bills are now printed to the device specified by the user. When printing is complete, a summary is displayed on the computer screen. The summary lists the batch number created, the number of bills, the number of insurers, and the dollar amount contained in the batch.

7.4 Print Worksheet (Itemized CPT Data) (WSPR)

Main Menu → PRTP→ WSPR

This option closely resembles the Detailed Display of Selective Claims Report (section 6.5). In this report, however, the user may print the worksheet (detailed claim display) for a single claim, list of claims, or the entire export (print) batch.

```
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
       |         THIRD PARTY BILLING SYSTEM - VER 2.5                        |
       +          Print Worksheet (Itemized CPT Data)                       +
       |                        SELLS HOSP                                   |
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
       User: MAROFSKY,SANDRA                      2-FEB-2002 2:02 PM

PRINT WORKSHEET FOR:

     Select one of the following:

          1         SELECTIVE CLAIMS
          2         ALL CLAIMS FOR AN EXPORT DATE

Select Desired Option: 1  SELECTIVE CLAIMS
```

Figure 7-8: Print Worksheet Setup

7.5 Print Mailing Address Labels (MLPR)

Main Menu → PRTP → MLPR

Two methods exist for determining which insurer mailing labels to print: select a list of individual insurers or choose to print labels for all insurers in a batch.

If the user chooses to select individual insurers to print labels for, the system will prompt him or her for the insurers by name. When the user has entered selected all of the insurers he or she wishes to print labels for, the system will prompt the user for the number of labels (per insurer) to print, the number of lines to print on each label, and the desired output device (Figure 7-9).

```
Select 1st INSURER: new Mexico med
( MED/MEDCARE/MEDCENTER/MEDICAID/MEDICAL/MEDICARE/MEDIGROUP/MEDMARK MEXICO NEW )

NEW MEXICO MEDICAID                  - 999 MENAUL
                                       ALBUQUERQUE, NM 87108
 OK? Y//

Select 2nd INSURER:

Enter Desired Number of Labels Printed Per Insurer:  (1-50): 1//

Enter the Number of Lines per Label:  (4-8): 6//

               (NOTE: Mailing Labels need to be loaded in the printer.)

Output DEVICE:

PRINT TEST ALIGNMENT PATTERN? N// O
```

Figure 7-9: Selecting Insurer Mailing Labels to Print

If the user chooses to print labels for all insurers in a batch, he or she will be prompted to print all export batches not previously printed. If the user does not wish to print all export batches not previously printed, he or she is then prompted to select a specific batch (Figure 7-10).

One the user has selects a batch or set of batches to print, he or she will be asked to specify the number of labels to print per insurer and the number of lines to print on each label.

The system reminds the user to load the printer with mailing labels and prompts the user for an output device. Test labels can be printed to ensure the labels are loaded in the printer properly.

```
Print Labels for all EXPORT BATCHES that haven't been Previously Printed? N// O

Select 1st EXPORT BATCH (NUMBER or DATE): t JUL 02, 1997  HCFA-1500B ALL SOURCES
MAROFSKY,SANDRA

Select 2nd EXPORT BATCH (NUMBER or DATE):

Enter Desired Number of Labels Printed Per Insurer:  (1-50): 1//

Enter the Number of Lines per Label:  (4-8): 6//

               (NOTE: Mailing Labels need to be loaded in the printer.)

Output DEVICE:

PRINT TEST ALIGNMENT PATTERN? N// O
```

Figure 7-10: All Insurers for a Batch Label Printing

Finally, the labels are printed and the user is prompted to select another insurer. The user can press the Return key at the insurer prompt to return to the Print Bills menu or repeat the process of selecting bills for printing.

7.6 Reprint Bill (REPR)

Main Menu → PRTP→ REPR

Once a bill has been printed, it may be reprinted at any time through the REPR option. The user may reprint a single bill, a list of bills, all bills for an export batch, or unpaid bills.

```
      +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
      |          THIRD PARTY BILLING SYSTEM - VER 2.5                       |
      +                      Reprint Bill                                   +
      |                       SELLS HOSP                                    |
      +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
      User: WESLEY,PAUL                     16-APR-1992 12:38 PM

   Re-Print Bills for:

     Select one of the following:

          1         SELECTIVE BILL(S)
          2         ALL BILLS FOR AN EXPORT BATCH
          3         UNPAID BILLS

    Select Desired Option:
```

Figure 7-11: Reprint Bill Option

Selective Bills
The user may select individual bills to be printed.

NOTE: Only those bills that have previously been printed may be selected. The system will continuously prompt for a bill to reprint until a null value is entered. This allows the user to reprint a specific list of bills.

```
Select 1st BILL to Re-Print: 31A
          Visit: 11-10-89 OUTPATIENT      CARDIAC      SELLS HOSP
           Bill: NON-BENEFICIARY PATIENT  HCFA-1500B  95.64

Select 2nd BILL to Re-Print:

          (NOTE: HCFA-1500B forms need to be loaded in the printer.)

Output DEVICE:
Printing...
                  (Print bills to printer)

                 (All Print-outs are Complete)
                 ============================
                 Number of Records Exported: 1
                 Number of Insurers........: 1
                 Total Amount Billed.......: 95.64

Enter RETURN to continue or '^' to exit:
```

Figure 7-12: Selective Bill(s)

All Bills For An Export Batch

The user may choose to reprint all the bills in an export batch. The system will ask the user to specify which batch to reprint.

```
Select EXPORT BATCH (Date): JUL 02, 1997  HCFA-1500B  ALL SOURCES
                                                        MAROFSKY,SANDRA
    (NOTE: HCFA-1500B forms need to be loaded in the printer.)

Output DEVICE:
Printing...
                  (print bills to printer)
                (All Print-outs are Complete)

     For Printing Mailing Labels, Worksheets or a Transmittal Listing...
     ...refer to EXPORT BATCH: 19
                 ==========================
                 Number of Records Exported: 1
                 Number of Insurers........: 1
                 Total Amount Billed.......: 2,910.00

Enter RETURN to continue or '^' to exit:
```

Figure 7-13: All Bills for an Export Batch

Unpaid Bills

This option allows the user to reprint only Unpaid Bills. The user must select the mode of export to reprint and limit the number of bills to reprint through the exclusion parameters.

```
Select FORM to Re-Print: ?
 Answer with 3P EXPORT MODE NUMBER, or FORMAT
Choose from:
   1               UB-82      OMB NO. 0938-0279
   2               HCFA-1500A      Old Version Dated 1-84
   3               HCFA-1500B      New Version Dated 12-90
   4               ADA-90       Dental Claim Form Dated 1990
   10              UB-92-E V4      UB-92 Electronic (NSF Version 4)
   11              UB-92      OMB NO. 0938-0279
   12              ADA-94       DENTAL ADA-94 FORM
   13              UB-92-E V5      Electronic UB-92 (NSF Version 5)
   14              HCFA-1500 Y2K      HCFA 1500 Y2K version
   15              HCFA-1500-E      Electronic HCFA-1500 (NSF Version 2.0)

Select FORM to Re-Print: 3  HCFA-1500B        New Version Dated 12-90

For the parameters specified, the
           Number of Bills to Reprint: 1

          (NOTE: HCFA-1500B forms need to be loaded in the printer.)

Output DEVICE:

Printing...

                  (print bills to printer)

                  (All Print-outs are Complete)
                  ============================
                  Number of Records Exported: 1
                  Number of Insurers.........: 1
                  Total Amount Billed........: 95.64

Enter RETURN to continue or '^' to exit:
```

Figure 7-14: Unpaid Bills Report

NOTE: After reprinting the bills, regardless of how the bills were selected, the user is given summary data concerning those bills. The system monitors the batch, if applicable, number of bills, number of insurers, and total amount billed.

7.7 Transmittal Listing (TRPR)

Main Menu → PRTP→ TRPR

A transmittal list is a listing of all entries (bills) contained in an export batch. Two different transmittal lists exist. The first is a continuous listing sorted by location and visit type, used for internal management and record keeping. The second is a listing with each insurer on a separate page, used as an attachment to a cover letter for submission with the bills.

```
     +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
     |          THIRD PARTY BILLING SYSTEM - VER 2.5                          |
     +                  Transmittal Listing                                   +
     |                       SELLS HOSP                                       |
     +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
     User: WESLEY,PAUL                      15-APR-1992  2:30 PM

List BILLS for all EXPORT BATCHES that haven't been Previously
Printed? Y// NO

Select 1st EXPORT BATCH (NUMBER or DATE): 20  5-6-1992 <RETURN>
HCFA-1500A  ALL SOURCES  DANIELSON,THOMAS
Select 2nd EXPORT BATCH (NUMBER or DATE): 23  6-10-1992 <RETURN>
WI-MCD-DEN  ALL SOURCES  DANIELSON,THOMAS
Select 3rd EXPORT BATCH (NUMBER or DATE): <RETURN>

AVAILABLE REPORTS:
==================

     Select one of the following:

          1         Sorted by LOCATION/VISIT TYPE
          2         Separated by INSURER for attachment to COVER LETTERS

Select desired REPORT TYPE:
```

Figure 7-15: Transmittal Listing

7.7.1 Transmittal List For Internal Use

```
        WARNING: CONFIDENTIAL PATIENT INFORMATION, PRIVACY ACT APPLIES
================================================================================
TRANSMITTAL LIST (EXPORT NO: 20,23)                    JUN 15,1992   PAGE 1
================================================================================
                              BILL                                      BILL
       PATIENT               NUMBER      ACTIVE INSURER                AMOUNT
--------------------------------------------------------------------------------
               VISIT LOCATION: SELLS HOSP
INPATIENT
     DANIELSON,EUN             6B      ALASKA VISION SERVICES INC   4,434.00
                              ------                                  ---------
                 SUBTOTAL:      1                                    4,434.00

DENTAL
     BONDS,DENNIS             110C     WISCONSIN MEDICAID              80.00
     GARDNER,DARLENE          106B     WISCONSIN MEDICAID             310.00
     GARDNER,DARLENE          109B     WISCONSIN MEDICAID             176.00
                              -----                                  ---------
SUBTOTAL:                       3                                     566.00
                              =====                                  ==========
          TOTAL:                4                                   5,000.00
```

Figure 7-16: Sorted By Location/Visit Type

7.7.2 Transmittal List For Cover Letters

An example of the transmittal list intended for submission with a cover letter to each billed insurer is shown below. This report form feeds on each insurer change.

```
         WARNING: Confidential Patient Information, Privacy Act Applies
================================================================================
TRANSMITTAL LIST FOR ALASKA VISION SERVICES INC          JUN 15,1992   PAGE 1
================================================================================
                            Bill    Visit       Visit                  Bill
     Patient               Number   Date       Location               Amount
--------------------------------------------------------------------------------
DANIELSON,EUN                6B     09/01      SELLS HOSP             4,434.00
                            ------                                    ---------
       SUBTOTAL:              1                                      4,434.00

================================================================================
TRANSMITTAL LIST FOR WISCONSIN MEDICAID              JUN 15,1992   PAGE 1
================================================================================
                            Bill     Visit       Visit                  Bill
     Patient               Number    Date       Location               Amount
--------------------------------------------------------------------------------
BONDS,DENNIS                 110C    04/05    SELLS HOSP                80.00
GARDNER,DARLENE              106B    03/26    SELLS HOSP               310.00
                             109B    04/07    SELLS HOSP               176.00
                            ------                                    ----------
       SUBTOTAL:              3                                        566.00

================================================================================
TRANSMITTAL LIST FOR WISCONSIN MEDICAID               JUN 15,1992   PAGE 2
================================================================================
                            Bill     Visit       Visit                  Bill
     Patient               Number    Date       Location               Amount
--------------------------------------------------------------------------------
                            ------                                    ----------
          TOTAL:             4                                      5,000.00
```

Figure 7-17: Transmittal List For Cover Letters

7.8 Test Forms Alignment (TSPR)

Main Menu → PRTP→ TSPR

This option enables the user to test the alignment of specified forms before actually printing. The system will continue to print test forms until the user responds that the alignment is correct.

Step 1: Type the form (mode) type at the "Select 3P Export Mode Format:" prompt.

Step 2: Type the name of the device you wish to print the test form on at the "Device:" prompt. The test form(s) should be printed on the device that you intend to print the real forms on.

Step 3: If the right margin of the device is different than the standard 80, type the right margin number at the "Right Margin: 80//" prompt. If the right margin is supposed to be 80 (or you are unsure of the printers margin), press the Return key at the "Right Margin: 80//" prompt to accept the default.

Step 4: After the test form has been sent to the device for printing, the system will notify the user. Type Y or N at the "Is the alignment correct? Y//" prompt. If you type Y, you will be returned to the Print Bills menu. If you type N, the system will send another test page to the printer. If the alignment on your test sheet is not correct, make the necessary adjustments to the printer alignment before you type N at the "Is the alignment correct? Y//" prompt. Repeat step 4 until the form alignment is correct.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |          THIRD PARTY BILLING SYSTEM - VER 2.5                            |
           +                    Test Forms Alignment                                  +
           |                         SELLS HOSP                                       |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: MAROFSKY,SANDRA                        2-APR-1997 4:00 PM

Select 3P EXPORT MODE FORMAT: UB-92

DEVICE: HOME//     RIGHT MARGIN: 80//

      (test form prints to specified device)

IS THE ALIGNMENT CORRECT? Y// Y   Yes
```

Figure 7-18: Test Forms Alignment

8 Table Maintenance Menu (TMTP)

Main Menu → TMTP

The Table Maintenance options enable the user to manage the specific files that are instrumental to the billing process. The available management tools vary by file type, but may include editing, listing, merging, inquiring, or establishing keyword entries.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
          +                 Table Maintenance Menu                  +
          |                  ALBUQUERQUE HOSPITAL                   |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                          5-MAR-2002 3:42 PM

   FETM   Fee Schedule Menu ...
   CPTM   CPT File Menu ...
   PRTM   Inquire to Provider File
   LOTM   Location File Menu ...
   INTM   Insurer File Menu ...
   COTM   Coverage Type File Menu ...
   SITM   Site Parameter Maintenance
   ERTM   Error Codes Menu ...
   GRTM   Group Insurance Plans Menu ...
   RVTM   Revenue Codes Menu ...
   UCTM   UB-92 Codes Menu ...
   EMTM   Employer File Menu ...
   DRTM   Drug File Menu ...
   VITM   Visit Type Maintenance
   CMTM   Charge Master Add/Edit
   DMTM   Dental Remap Table Maintenance
   FLTM   Form Locator Override
   SSTM   Initialize New Facility

Select Table Maintenance Menu Option:
```

Figure 8-1: Table Maintenance Menu

8.1 Fee Schedule Menu (FETM)

Main Menu → TMTP→ FETM

8.2 Fee Schedule Menu

This menu enables users to update their own fee schedules. These fee tables contain the charges for each good or service rendered. Each site is responsible for maintaining their tables; the fee schedules are no longer distributed or maintained by IHS National Programs.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |         THIRD PARTY BILLING SYSTEM - VER 2.5                        |
          +                    Fee Schedule Menu                               +
          |                        SELLS HOSP                                   |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: MAROFSKY,SANDRA                        3-APR-1997 9:18 AM


   EDFE   Fee Schedule Maintenance
   LSFE   Print Fee Schedule Listing
   RPFE   CPT-Corresponding ICD-Fee Listing
   ASFE   Update ASC Fee Schedule
   DTFE   Transfer Drug Prices from Drug file
   FIFE   Import Foreign Fee Schedule
   IDFE   Increase/Decrease Fee Schedule

Select Fee Schedule Menu Option:
```

Figure 8-2: Fee Schedule Menu

The Fee Schedule menu contains a maximum of seven options, each of which is outlined in this section.

8.2.1 Fee Schedule Maintenance (EDFE)

Main Menu → TMTP→ FETM → EDFE

This option enables the user to modify charges associated with goods and services provided. Keeping these fees up to date is an important part of generating revenue.

Step 1: Type the fee table schedule number at the "Select Fee Schedule:" prompt. If you need to see a list of options, type a question mark (?) at the prompt first. If you wish to create a new fee schedule instead of editing an existing one, type a new fee schedule number at the prompt. Adding a fee schedule through this option is similar to editing an existing fee schedule, but you will not see an existing entry at the prompts (behind the two slashes (//)).

> **Note**: Each site may have its own fee schedule. Only the fee schedule owner is allowed to modify it, providing one level of security. Multiple fee tables per site may be necessary if different insurers pay at different rates. For example, Medicare OP Surgery rates differ from other insurers and must be charged accordingly.

Step 2: Type the number that corresponds to the fee schedule category that you wish to edit at the "Select Desired Category:" prompt. The system will automatically display your category options before the prompt.

Step 3: Type the CPT/ ICD/other code that you wish to edit at the "Select [category name] code:" prompt.

Items in the Medical, Surgical, Radiology, Laboratory, and Anesthesia Fee categories are restricted to certain CPT code ranges. For example, if the user chose the Medical Fee category, only medical CPT codes are allowed for entry at this prompt. Items in the Dental Fees category are identified by ADA codes, Revenue Code Fees by revenue codes, HCPCS Fees by HCPCS code. If choosing an item for Drug Fees or Charge Master category, the item must first exist in the Drug or Charge Master file (respectively). However, entry of a new Charge Master item into the Charge Master file is allowed at this prompt.

> **Note:** When entering fees for IVs, the charge must be per unit of measure. For the calculation to be performed correctly, the unit of measure used here must be the same as the unit of measure entered in the Drug file by the pharmacist.

In the example in Figure 8-3, the user is prompted for a CPT code because he chose Medical as his fee schedule category. If the system finds a match for the code you type at the "Select [category name] code:" prompt, it will display additional information below your entry so that you can verify your selection.

> **Note**: If the code you select has not already been assigned to the fee table, the system will ask you if you wish to add it. If you type Y, skip to step 5. If you type N, repeat step 3.

Step 4: Type Y or N at the "OK? Y//" prompt. If you type N, the system will return you to the "Select [category name] code:" prompt (step 3). If you type Y, the system will display the last date that the code was updated.

Step 5: Type the new charge at the "Charge: [old charge]//" prompt. The existing charge (if there is one) will appear as the default (before the two slashes (//)) for your reference. Press the Return key when you are finished typing the new charge. You will be returned to the "Select [category name] Code:" prompt (step 3).

> **Note**: For an item to be selectable in the claim editor, a corresponding charge in the fee table must be greater than zero.

```
Select FEE SCHEDULE: 1// ?
Answer with 3P FEE TABLE SCHEDULE NUMBER
Choose from:
   1      IHS STANDARD FEE SCHEDULE
   2      MEDICARE O/P SURGERY

     You may enter a new 3P FEE TABLE, if you wish
     Type a Number between 1 and 999, 0 Decimal Digits

Select FEE SCHEDULE: 1// 1         IHS 1995 STANDARD FEE SCHEDULE
----- FEE SCHEDULE CATEGORIES -----

Select one of the following:

          1         MEDICAL FEES
          2         SURGICAL FEES
          3         RADIOLOGY FEES
          4         LABORATORY FEES
          5         ANESTHESIA FEES
          6         DENTAL FEES
          7         REVENUE CODE
          8         HCPCS FEES
          9         DRUG FEES
          10        CHARGE MASTER

Select Desired CATEGORY: 1  MEDICAL FEES
Select MEDICAL (CPT CODE): 90720       DTP/HIB VACCINE
       IMMUNIZATION, ACTIVE; DIPHTHERIA, TETANUS TOXOIDS, AND PERTUSSIS
       (DTP) AND HEMOPHILUS INFLUENZA B (HIB) VACCINE
         ...OK? Yes// Y  (Yes)     - DTP/HIB VACCINE                  35.00
Last Updated: 06/30/1997

CHARGE: 35// 45
```

Figure 8-3: Fee Schedule Maintenance

8.2.2 Print Fee Schedule Listing (LSFE)

Main Menu → TMTP→ FETM → LSFE

The LSFE option enables users to display a listing of the entries in a fee schedule.

Step 1: Type the fee table schedule number at the "Select Fee Schedule:" prompt. If you need to see a list of options, type a question mark (?) at the prompt first.

Step 2: Type the number that corresponds to the fee schedule category that you wish to edit at the "Select Desired Category:" prompt. The system will automatically display your category options before the prompt.

Step 3: Type the name of the device you wish to print or view the list on at the "Device:" prompt.

```
Select FEE SCHEDULE: 1// 1          IHS 1995 STANDARD FEE SCHEDULE

======== FEE SCHEDULE CATEGORIES ========


     Select one of the following:

          1         MEDICAL
          2         SURGICAL
          3         RADIOLOGY
          4         LABORATORY
          5         ANESTHESIA
          6         DENTAL
          7         REVENUE CODE
          8         HCPCS
          9         DRUG
          10        CHARGE MASTER

Select Desired CATEGORY: 1  MEDICAL



DEVICE: HOME
```

Figure 8-4: Setting Up a Fee Schedule Listing

8.2.3 CPT- Corresponding ICD-Fee Listing (RPFE)

Main Menu → TMTP→ FETM → RPFE

The CPT-Corresponding ICD-Fee Listing option will display every active CPT code in the CPT file regardless of whether that code has an entry in the selected fee schedule. If a corresponding ICD description exists, it will be displayed.

Step 1: Type the fee table schedule number at the "Select Fee Schedule:" prompt. If you need to see a list of options, type a question mark (?) at the prompt first.

Step 2: Type the number that corresponds to the fee schedule category that you wish to edit at the "Select Desired Category:" prompt. The system will automatically display your category options before the prompt.

Step 3: Type the name of the device you wish to print or view the list on at the "Device:" prompt.

Step 4: Type Y or N at the "Should Output be in CONDENSED PRINT (Y/N)? Y//" prompt. The system will only be able to print your report in condensed print if the device you selected in step 3 supports it. Type N if you are printing the report to the screen.

```
Select FEE SCHEDULE: 1// 1          IHS 1995 STANDARD FEE SCHEDULE

======== FEE SCHEDULE CATEGORIES ========

     Select one of the following:

          1         MEDICAL
          2         SURGICAL-ANESTHESIA
          3         RADIOLOGY
          4         LABORATORY

Select Desired CATEGORY: 1  MEDICAL

NOTE: Report requires 132 Width Export Format!

Output DEVICE: HOME

     (This report requires 132 Width export format)

Should Output be in CONDENSED PRINT (Y/N)? Y// Y
```

Figure 8-5: CPT-Corresponding ICD-Fee Listing

Figure 8-6 is an example of a CPT-Corresponding ICD-Fee report.

```
Date: JUL 3,1997        ~~~~~~~~~~ MEDICAL LISTING - IHS 1995 STANDARD FEE SCHEDULE ~~~~~~~~~~          Page: 1
CPT                                                                  ICD       CORRESPONDING                FEE
CODE  -       CPT DESCRIPTION                                        CODE  -   ICD DESCRIPTION            AMOUNT
================================================================================================================
90700 - IMMUNIZATION, ACTIVE; DIPHTHERIA, TETANUS TOXOIDS, AND                                             30.00
         ACELLULAR PERTUSSIS VACCINE (DTAP)
90701 - IMMUNIZATION, ACTIVE; DIPHTHERIA AND TETANUS TOXOIDS AND     99.39 - DPT ADMINISTRATION            30.00
         PERTUSSIS VACCINE (DTP)
90702 - IMMUNIZATION, ACTIVE; DIPHTHERIA AND TETANUS TOXOIDS         99.36 - DIPHTHERIA TOXOID ADMIN       16.00
         (DT)
90703 - IMMUNIZATION, ACTIVE; TETANUS TOXOID                         99.38 - TETANUS TOXOID ADMINIST       16.00

90704 - IMMUNIZATION, ACTIVE; MUMPS VIRUS VACCINE, LIVE              99.46 - MUMPS VACCINATION             19.00

90705 - IMMUNIZATION, ACTIVE; MEASLES VIRUS VACCINE, LIVE,           99.46 - MUMPS VACCINATION             19.00
         ATTENUATED

Enter RETURN to continue or '^' to exit: ^
```

Figure 8-6: CPT-Corresponding ICD-Fee Report

8.2.4 Update ASC Fee Schedule (ASFE)

Main Menu → TMTP→ FETM → ASFE

Eight ASC groups exist and each group is assigned a fee by Medicare. This option will automatically update the fees in the ASC fee schedule for each CPT code related to an ASC group.

The benefit of updating the ASC Fee Schedule through this option is that the user enters the rate for each group only once, and the system automatically updates the corresponding CPT codes. The more tedious alternative to this option is to update the rate of each CPT code individually through the Fee Schedule Maintenance option (section 8.2.1).

Note: It is strongly recommended that you do a global save of global ^ABMDFEE before proceeding with this option.

Step 1: Type the fee table schedule number at the "Enter the Number of your Fee Schedule:" prompt. If you need to see a list of options, type a question mark (?) at the prompt and make your selection from the list of options that appears.

Step 2: Type the rates for the eight ASC payment groups at the "Enter Rate for ASC Payment Group #1:" through the "Enter Rate for ASC Payment Group #8:"prompts.

Step 3: The system will display your payment group rates for your review. Type Y or N at the "Continue? No//" prompt. The system will only update the group payment rates if you type Y. If you type N, you will be returned to the Fee Schedule menu.

```
Enter the Number of your ASC Fee Schedule: 2// ?
 Answer with 3P FEE TABLE NUMBER, or SCHEDULE NUMBER
Choose from:
   1               1      IHS 1995 STANDARD FEE SCHEDULE
   2               2      MEDICARE O/P SURGERY
   3               3      SHURZ
   4               4      NAVAJO AREA FEE TABLE

Enter the Number of your ASC Fee Schedule: 2// 2         MEDICARE O/P SURGERY
Enter Rate for ASC Payment Group #1:  23
Enter Rate for ASC Payment Group #2:  45
Enter Rate for ASC Payment Group #3:  43
Enter Rate for ASC Payment Group #4:  65
Enter Rate for ASC Payment Group #5:  87
Enter Rate for ASC Payment Group #6:  92
Enter Rate for ASC Payment Group #7:  152
Enter Rate for ASC Payment Group #8:  185

================================================================================

Rate for ASC Payment Group 1: $23
Rate for ASC Payment Group 2: $45
Rate for ASC Payment Group 3: $43
Rate for ASC Payment Group 4: $65
Rate for ASC Payment Group 5: $87
Rate for ASC Payment Group 6: $92
Rate for ASC Payment Group 7: $152
Rate for ASC Payment Group 8: $185
Continue? NO// YES..... ..................................................
........................ ..................................................
Finished.
Enter RETURN to continue or '^' to exit:
```

Figure 8-7: Update ASC Fee Schedule

During the update, the system reviews all items (CPT codes) in the ASC fee schedule. When a CPT code is found in the CPT file and the AS Payment Group field is populated with a number between 1 and 8, the rate you specified for that group (step 2) is assigned to the CPT code in the ASC fee schedule.

8.2.5 Transfer Drug Prices from Drug File (DTFE)

Main Menu → TMTP→ FETM → DTFE

This option enables the user to automatically transfer the Average Wholesale Price (AWP) price per dispense unit or the cost per dispense unit from the Drug file to the Third Party Billing Fee table. These values from the Drug file will be used to populate the specified fee table in Third Party Billing. Before transferring the fees, the user may elect to apply a specified percentage increase or decrease.

Note: Save the global ABMDFEE before executing this option.

Step 1: Type Y or N at the "Continue? No//" prompt. If you type N, you will be returned to the Fee Schedule menu.

Step 2: Type the fee table entry number at the "Update which Fee Table Entry:" prompt. If you need to see a list of options, type a question mark (?) at the prompt and make your selection from the list of options that appears.

Step 3: Type the number that corresponds to the Drug file field that you wish to transfer data from at the "Select Field from Drug file to Transfer: 1//" prompt.

Step 4: Type Y or N at the "Apply Percentage Increase or Decrease?" prompt. If you type **Y**, you will apply a percentage increase/decrease to the price before storing it in the Third Party Billing Fee Table. If you do not want to apply an increase or decrease to the price, type N and skip to step 7.

Step 5: Type 1 (increase) or 2 (decrease) at the "Enter Response:" prompt.

Step 6: Type the percentage that you wish to either increase or decrease the price by at the "Enter Percent (0-99999):" prompt. This number should be entered as a whole number (e.g., type 10 for 10%).

Step 7: The system will display a review of your selections. Verify that you've entered your selections correctly and type Y or N at the "Continue: No//" prompt. If you type Y, the system will process the drug data transfer. If you type N, you will be returned to the Fee Schedule menu.

```
Continue? NO// YES

Update which Fee Table Entry? 1// 1         IHS 1995 STANDARD FEE SCHEDULE

     Select one of the following:
          1         Average Wholesale Price (AWP) per Dispense Unit
                    (field# 9999999.32)
          2         Price (cost) per Dispense Unit (field# 16)

Select Field from Drug file to Transfer: 1// 1  Average Wholesale Price (AWP)
per Dispense Unit                                (field# 9999999.32)

Apply percentage increase or decrease? NO// Y YES

     Select one of the following:

          1         INCREASE
          2         DECREASE

Enter response: 1  INCREASE
Enter percent:  (0-99999): 10// 10

I will move the Average Wholesale Price per Dispense Unit field from the
Drug file to the 3P Fee Table.
I will apply a 10 percent increase.

Continue? NO// YES .....................................................
Finished.
Enter RETURN to continue or '^' to exit
```

Figure 8-8: Transfer Drug Prices from Drug File

8.2.6 Import Foreign Fee Schedule (FIFE)

Main Menu → TMTP→ FETM → FIFE

This option enables the user to update a fee schedule using fees supplied by a third party vendor.

> **Note**: Do a global save of global ^ABMDFEE prior to running this procedure.

Step 1: Type Y or N at the "Continue? No//" prompt. If you type N, you will be returned to the Fee Schedule menu.

Step 2: Type the fee table entry number at the "Update which Fee Table Entry:" prompt. If you need to see a list of options, type a question mark (?) at the prompt and make your selection from the list of options that appears.

Step 3: Type the symbol used by the foreign fee schedule table to delineate the text at the "What is the host file record delimeter? ,//" prompt. The default response is the comma, used for comma delimited text files.

Step 4: Type the number of the host file piece that contains the CPT code at the "Which piece of the host file record contains the CPT code? 1//" prompt. If you need to see a list of options, type a question mark (?) at the prompt and make your selection from the list of options that appears.

Step 5: Type the number of the host file piece that contains the price associated with the CPT code at the "Which piece of the host file record contains the price? 2//" prompt.

Step 6: Type HFS (or the number assigned to your HFS) at the "Device: Host File Server//" prompt. The foreign fee schedule file should already reside on the UNIX system (Contact your Site Manager for assistance if this has not already been done).

Step 7: Type the path and name of the foreign fee schedule file at the "Host File Name:" prompt. The Input/Output Operation field will always be set to a capital R (read).

```
Continue? NO// YES
Enter Fee Schedule to Update: 1// 4          NAVAJO AREA FEE TABLE

FOREIGN HOST FILE DESCRIPTION

What is the host file record delimiter? ,// ,
Which piece of the host file record contains the CPT code? 1// 1
Which piece of the host file record contains the price? 2// 2
OPEN AND READ FOREIGN FILE

DEVICE: HOST FILE SERVER// HFS  HOST FILE SERVER #1
HOST FILE NAME: /usr3/dsd/donj/NAIHS.CSV            INPUT/OUTPUT OPERATION: R
10040,115
10060,146
10061,225
10081,278
10120,182
10121,286
10140,153
10160,120
```

Figure 8-9: Import Foreign Fee Schedule

Once the system has found the appropriate data in the foreign fee schedule file, the data will be displayed on the screen and transferred into the selected fee schedule.

8.2.7 Increase/ Decrease Fee Schedule (IDFE)

Main Menu → TMTP→ FETM → IDFE

This option enables the user to apply a percentage increase or decrease to a selected segment of or the entire fee schedule. In the example in Figure 8-10, the user chose to decrease all dental fees in the Navajo Area fee table by ten percent.

Step 1: Type Y or N at the "Continue? No//" prompt. If you type N, you will be returned to the Fee Schedule menu.

Step 2: Type the fee table schedule number at the "Select 3P Fee Table Schedule Number:" prompt. If you need to see a list of options, type a question mark (?) at the prompt and make your selection from the list of options that appears.

Step 3: Type 1 (if you wish to increase the fee schedule) or 2 (if you wish to decrease the fee schedule) at the "Enter response: 1//" prompt.

Step 4: Type the percentage that you wish to either increase or decrease the price by at the "Enter Percentage (0.01-100):" prompt.

Step 5: Type the number that corresponds to the fee schedule category that you wish to edit at the "Select Fee Schedule Category:" prompt. The system will automatically display your category options before the prompt. The system will display a summary of your selections on the screen (e.g., I am going to apply a 10 percent DECREASE to category…).

Step 6: Type Y or N at the "Are you sure? No//" prompt. If you type N, you will be returned to the Fee Schedule menu.

```
Continue? NO// YES

Select 3P FEE TABLE SCHEDULE NUMBER: 4          NAVAJO AREA FEE TABLE
Select one of the following:

          1         INCREASE
          2         DECREASE

Enter response: 1// 2  DECREASE
Enter PERCENTAGE:  (0.01-100): 10

     Select one of the following:

          1         ALL
          11        SURGERY
          13        HCPCS
          15        RADIOLOGY
          17        LABORATORY
          19        MEDICINE
          21        DENTAL
          23        ANESTHESIA
          25        DRUG
          31        ROOM & BOARD

Select FEE SCHEDULE CATEGORY: 21  DENTAL

I am going to apply a 10 percent DECREASE to category DENTAL
 for fee schedule #4.
ARE YOU SURE? NO// YES

Finished.
Enter RETURN to continue or '^' to exit:
```

Figure 8-10: Increase/Decrease Fee Schedule

8.3 CPT File Menu (CPTM)

Main Menu → TMTP→ CPTM

The CPT file is the procedure coding system established by the American Medical Association (AMA). This file is proprietary and requires that a license be obtained from the AMA.

```
      +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
      |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
      +                     CPT File Menu                       +
      |                       SELLS HOSP                        |
      +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+

   EDCP   CPT File Maintenance
   RPCP   Replacement Text for CPT File Lookups
   LSCP   Print CPT Procedure File
   IQCP   Inquire to CPT File
   MDCP   Modifiers Add/Edit

Select CPT File Menu Option:
```

Figure 8-11: CPT File Menu

NOTE: The CPT file is no longer distributed with this system; it is distributed as the ACPT package.

CPT Selection
The Keyword Lookup System currently used for the ICD Diagnosis and Procedure files has been adapted for selecting CPT entries also. This system enables the selection of a CPT record by either entering its code or a narrative description. When a narrative description is entered, prior to using it for lookup, replacement text is substituted for keywords and conjunctive words (less than 3 characters) are removed. Those CPT procedures that contain the altered text are displayed for selection.

Keywords for the Lookup System have not been provided for the CPT file. It is recommended that the local site establish its own keywords.

8.3.1 CPT File Maintenance (EDCP)

Main Menu → TMTP→ CPTM → EDCP

This option enables users to edit CPT codes. The user may choose to edit an existing CPT code or add a new one to the CPT Code file.

Step 1: Type 1 to edit an existing CPT code or type 2 to add a new CPT code to the file at the "Select Desired Action: 1//" prompt.

Step 2: If you chose to edit an existing CPT code, type the number of the CPT code you wish to edit at the "Select CPT Code to Edit:" prompt. The system will display the CPT description for your review.

If you chose to add a new CPT code, type the number of the CPT code you wish to add at the "Enter the CPT code:" prompt.

Step 3: Type Y or N at the "OK? Yes//" prompt (for CPT code edits) or the "Do you want to Add '[CPT number]' as a New CPT CODE?:" prompt (for CPT code additions) if the CPT code you typed in step 2 is correct.

Step 4: Edit or add the short name for the procedure. If you do not wish to edit the code's short name, just press the Return key and continue to step 5.

EDIT: the current Short Name entry will appear between the "Short Name:" prompt and the word *Replace*. If you wish to replace any of the short name text, you will first have to type the portion you wish to change or type three periods (…) to select the entire entry. Once you have selected the text to replace, press the Return key.

E.g., SHORTNAME: Needle Biopsy, Muscle Replace … <RETURN>

The system will follow the text (or three periods) with the word *With*. Type the text you want to replace the selection with at this prompt.

E.g., SHORTNAME: Needle Biopsy, Muscle Replace … with Muscle Biopsy, percutaneous needle

ADD: type the short name you wish to use for the new CPT code at the "Short Name:" prompt.

Step 5: Edit or add the CPT code's CPT category. If you do not wish to edit the code's CPT category, just press the Return key and continue to step 6.

EDIT: the current CPT category name will appear between the " CPT Category:" prompt and two slashes (//). If you do not wish to change the CPT category name, press the Return key without typing anything after the two slashes (//). If you do wish to change the CPT category name, type the new CPT category name after the two slashes (//) and press the Return key.

ADD: type the CPT category name for the procedure at the "CPT Category:" prompt.

Step 6: The system will display the current CPT description, followed by an "Edit? No//" prompt.

> **Note**: If you are adding a new CPT code, the system has automatically filled the CPT description field with the text you typed in for the CPT short name.

If you do not wish to edit the CPT description, press the Return key and continue to step 7. If you do wish to change the CPT description, type Y after the two slashes and press the Return key. The CPT description will appear on your screen in a text-editing screen, allowing you to make changes to the text. When you are finished editing the CPT description, press the F1 key and type E.

Step 7: Edit or add the CPT code's corresponding ICD code. If you do not wish to edit the CPT code's corresponding ICD code, just press the Return key and continue to step 8.

> **Note**: The CORRESPONDING ICD CODES field is no longer used as a crosswalk to CPT codes by the Third Party Billing system.

EDIT: the current CPT corresponding ICD code will appear between the " Select Corresponding ICD Codes:" prompt and two slashes (//). If you do not wish to change the corresponding ICD code, press the Return key without typing anything after the two slashes (//). If you do wish to change the corresponding ICD code, type the new ICD code after the two slashes (//) and press the Return key.

ADD: type the corresponding ICD code for the procedure at the "Select Corresponding ICD Codes:" prompt.

Step 8: Set the inactive flag. The inactive flag, if set, marks the CPT code as inactive and will prevent it from being displayed for selection in the Third Party Billing system. Type 1 at the "Inactive Flag:" prompt to set the flag or press the Return key to leave the flag unset.

> **Note**: The inactive flag is automatically removed when you edit a CPT code that has been previously flagged inactive.

Step 9: Type 1 (yes) or 0 (no) at the "Starred Procedure:" prompt. The Starred Procedure prompt allows the user to apply a warning message to this CPT code every time it is used. Only certain procedures in the Surgical category should be starred as specified in the CPT manual available.

Step 10: Type the revenue code number that corresponds to this CPT code at the "Default Revenue Code:" prompt. The value placed in the Default Revenue Code field is used as the Revenue Code for this CPT code everywhere in the system.

> **Note**: Users can change this value manually when they add the CPT code to a claim.

```
     Select one of the following:

          1         EDIT EXISTING CPT CODE
          2         ADD NEW CPT CODE

Select DESIRED ACTION: 1//   EDIT EXISTING CPT CODE


Select CPT CODE to Edit: 20206       NEEDLE BIOPSY, MUSCLE
       BIOPSY, MUSCLE, PERCUTANEOUS NEEDLE
         ...OK? Yes//   (Yes)

SHORT NAME: NEEDLE BIOPSY, MUSCLE  Replace

CPT CATEGORY: MUSCULOSKELETAL SYSTEM//
DESCRIPTION:
BIOPSY, MUSCLE, PERCUTANEOUS NEEDLE

  Edit? NO//
Select CORRESPONDING ICD CODES: 83.21//
INACTIVE FLAG:
STARRED PROCEDURE: YES//
DEFAULT REVENUE CODE:
```

Figure 8-12: CPT File Maintenance

8.3.2 Replacement Text for CPT File Lookups (RPCP)

Main Menu → TMTP→ CPTM → RPCP

The Replacement Text for CPT File Lookups option enables the user to establish replacement text for use by the CPT keyword lookup system.

Step 1: Type the text that you wish to automatically replace at the "Select Replaced Text:" prompt.

Step 2: The system will repeat the text you just typed between the "Replaced Text:" prompt and two slashes (//). If the text is correct, press the Return key. If the text is incorrect, type the correct text at the "Replaced Text:" prompt.

Step 3: Type the text that you wish to replace the selected text with at the "Replacement:" prompt.

In the example in Figure 8-13, the text to be replaced (UA) is first entered followed by the text that will serve as its replacement (URINALYSIS). Now, whenever *UA* is entered during a CPT selection, *urinalysis* will be substituted for it accordingly.

```
      +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
      |         THIRD PARTY BILLING SYSTEM - VER 2.5                          |
      +         Replacement Text for CPT File Lookups                         +
      |                        SELLS HOSP                                     |
      +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
      User: MAROFSKY,SANDRA                   15-APR-1997 11:04 AM

Select REPLACED TEXT: UA//
  REPLACED TEXT: UA//
  REPLACEMENT: URINALYSIS//
```

Figure 8-13: Replacement Text for CPT File Lookups

8.3.3 Print CPT Procedure File (LSCP)

Main Menu → TMTP→ CPTM → LSCP

The CPT File Listing displays the short narrative, long narrative, corresponding ICD codes, and inactivation status of the CPT codes in the CPT file. The listing can be restricted to a designated inclusive CPT Code range. The listing is in CPT Code order unless specified differently by the user.

Step 1: Type the field number or label that you wish to sort the list by at the "Sort by:" prompt. If you need to see a list of options, type two question marks (??) at the prompt first.

Step 2: Type the starting point in your selected sort field or label at the "Start with [field type]:" prompt. You can select First, Last, or a particular date, item, etc. (depending on what sort field or label you selected in step 1).

Step 3: Type the name of the device you wish to print or view the list on at the "Device:" prompt.

Step 4: If the right margin of the device is different than the standard 80, type the right margin number at the "Right Margin: 80//" prompt. If the right margin is supposed to be 80 (or you are unsure of the printers margin), press the Return key at the "Right Margin: 80//" prompt to accept the default.

```
SORT BY: CPT CODE// <RETURN>
START WITH CPT CODE: FIRST// <RETURN>
DEVICE: HOME    Right Margin: 80// <RETURN>
```

Figure 8-14: Printing the CPT Procedure File

8.3.4 Inquire to CPT File (IQCP)

Main Menu → TMTP→ CPTM → IQCP

The CPT Inquiry option enables the user to display and review all information for a selected CPT record.

Step 1: Type the number of the CPT code you wish to view at the "CPT Code:" prompt. The system will display the short name and the description information for your review.

Step 2: Verify that you have selected the correct CPT code. Type Y or N at the "OK? Yes//" prompt. If you type N, you will be returned to the CPT File Menu.

```
Select CPT PROCEDURE: 20206       NEEDLE BIOPSY, MUSCLE
       BIOPSY, MUSCLE, PERCUTANEOUS NEEDLE
         ...OK? Yes// Y  (Yes)
```

Figure 8-15: Inquiring to a CPT Record

Only the fields that contain data will be displayed on an inquiry.

```
                      *** CPT PROCEDURE FILE INQUIRY ***

================================================================================
CPT CODE: 20206                          SHORT NAME: NEEDLE BIOPSY, MUSCLE
  CPT CATEGORY: MUSCULOSKELETAL SYSTEM  ASC PAYMENT GROUP: 01
  STARRED PROCEDURE: YES
 DESCRIPTION:   BIOPSY, MUSCLE, PERCUTANEOUS NEEDLE
CORRESPONDING ICD CODES: 83.21
================================================================================


Select CPT PROCEDURE:
```

Figure 8-16: CPT Procedure File Inquiry

8.3.5 LAB CPT Codes To Pass To TPB (LACP)

Main Menu → TMTP→ CPTM → LACP

The LACP menu enables entry of Pathology, Cytology, and Blood Bank CPT codes into the 3P CPT Code file. Once the codes reside in 3P CPT Code File and they have been entered into PCC through the CPT Mnemonic option, the claim generator code has been updated to pass the information to Third Party Billing.

Historically, Pathology, Cytology, and Blood Bank codes were never sent to PCC. As a result, the Third Party Billing system did not pick up those lab codes. Also, several IHS sites that do not use the Laboratory package were using the CPT mnemonic option in PCC. Those lab codes were not designed to cross over to the Third Party Billing package.

Third Party Billing has been modified to allow Laboratory CPT codes to pass to Third Party Billing. The user must first setup these parameters through the CPT File Maintenance option (section 8.3.1).

Step 1: Type the table entry number at the "Lab CPT Table Entry:" prompt.

Step 2: Type Y or N at the "Are you adding a new 3P CPT TABLE? No//" prompt. If you type N, you will be returned to the CPT File menu.

Step 3: Type the table entry number (again) at the "Level:" prompt.

Step 4: Type the beginning number for a range of CPT codes at the "Low CPT:" prompt. If you want all lab codes to cross, type 80000. If you only want Pathology codes to cross, type 88300.

Step 5: Type the end number for a range of CPT codes at the "High CPT:" prompt. If you want all lab codes to across, type 89999. If you only want Pathology codes to cross, type 88399.

```
Select Lab CPT table entry: 18
  Are you adding a new 3P CPT TABLE? No// Y  (Yes)
   LEVEL: 18
Low CPT: :  (80000-89999): // 80000
High CPT: :  (80000-89999): // 89999
Select Lab CPT table entry:
```

Figure 8-17: Entry of Pathology, Cytology, and Blood Bank CPT Codes

8.3.6 Modifiers Add/Edit (MACP)

Main Menu → TMTP→ CPTM → MACP

This option enables users to add or change a CPT modifier code. This means that when new modifier codes come out, the users do not have to wait for a developer to put it in the system; users can update the file by entering the code and description themselves.

Step 1: Type the modifier code you wish to add or edit at the "Select CPT Modifier Code:" prompt.

Step 2: Verify your selection.

EDIT: If you are editing a modifier that is already entered in the CPT file, the system will display additional information on your screen for verification. Type Y or N at the "…OK? Yes//" prompt. If you type N, you will be returned to the "Select CPT Modifier Code:" prompt (step 1).

ADD: If you are adding a modifier, the system will ask you to verify your addition. Type Y or N at the "Are you adding '[number]' as a new CPT MODIFIER (the [number] TH)? No//" prompt. If you type N, you will be returned to the "Select CPT Modifier Code:" prompt (step 1).

Step 3: Type the revised or new description for the modifier at the "Description:" prompt. If a description is already on file for the modifier, it will appear between the prompt and two slashes (//). Your description cannot be any longer than 150 characters.

Step 4: Type the date that the modifier was added to the system at the "Date Added:" prompt. If a date is already on file for this prompt, it will appear between the prompt and

two slashes (//). Type a new date after the slashes to replace the existing date or press the Return key to accept the date already on file.

Step 5: Type the date that the modifier was deleted (if you are editing a modifier out of the system) at the "Date Deleted:" prompt. If a date is already on file for this prompt, it will appear between the prompt and two slashes (//). Type a new date after the slashes to replace the existing date or press the Return key to accept the date already on file.

```
Select CPT MODIFIER CODE: 76          REPEAT PROCEDURE BY SAME PHYSICIAN
         ...OK? Yes// Y (Yes)
DESCRIPTION: MULTIPLE MODIFIERS//
DATE ADDED: 12345// T     (MAR 12, 2002)
DATE DELETED:<RETURN>
```

Figure 8-18: Modifiers Add/Edit

8.4 Inquire to Provider File (PRTM)

Main Menu → TMTP → PRTM

The Inquire to Provider File option enables the user to view all information contained in the Provider file for a selected provider. Only those fields that contain data are presented through the inquire option.

To view a provider's file information, type the provider's name at the "Select Provider:" prompt. If the system finds a match in the Provider file, the information will be displayed on your screen.

```
                          *** PROVIDER FILE INQUIRY ***
================================================================================
NAME: MEDICAL,DOCTOR                      INITIAL: DM
  PERSON FILE POINTER: MEDICAL,DOCTOR     STREET ADDRESS 1: MD ADRS ONE
  STREET ADDRESS 2: MD ADRS TWO           STREET ADDRESS 3: THREE ADRS MD
  CITY: ALBUQUERQUE                       STATE: NEW MEXICO
  ZIP CODE: 87188                         SEX: MALE
  DOB: MAY 31, 1945                       DATE ENTERED: APR 05, 1991
  CREATOR: ADAM,ADAM                      SSN: 333333334
  DEGREE: MD                              SERVICE/SECTION: MEDICINE
  SIGNATURE BLOCK PRINTED NAME: DOCTOR MEDICAL
  SIGNATURE BLOCK TITLE: MD
KEY: PROVIDER                             GIVEN BY: SLEUTH,EDWARD
  DATE GIVEN: JAN 05, 1998
  AFFILIATION: TRIBAL                     CODE: C2
  IHS LOCAL CODE: C3                      MEDICARE PROVIDER NUMBER: PHS000
  MEDICAID PROVIDER NUMBER: NM29387       UPIN NUMBER: PHS000
  IHS ADC INDEX: 300C2
PAYER ASSIGNED PROVIDER NUMBER: ARIZONA MEDICAID
  NUMBER: AZ87939
PAYER ASSIGNED PROVIDER NUMBER: UNITED HEALTHCARE
  NUMBER: UHCPRV
  AUTHORIZED TO WRITE MED ORDERS: YES     DEA#: ZA7733774
  VA#: 8833774411                         PROVIDER CLASS: PHYSICIAN
```

```
  PROVIDER TYPE: FULL TIME
LICENSING STATE: ARIZONA                LICENSE NUMBER: A434524
LICENSING STATE: CALIFORNIA             LICENSE NUMBER: CA33459
  EXPIRATION DATE: JAN 01, 1999
LICENSING STATE: COLORADO               LICENSE NUMBER: CO494320
LICENSING STATE: FLORIDA                LICENSE NUMBER: 328SAB
LICENSING STATE: KANSAS                 LICENSE NUMBER: KA83283092
LICENSING STATE: NEW MEXICO             LICENSE NUMBER: 1234567
LICENSING STATE: WYOMING                LICENSE NUMBER: WY12394
  EXPIRATION DATE: JAN 01, 1999
================================================================================
```

Figure 8-19: Inquire to a Provider

8.5 Location File Menu (LOTM)

Main Menu → TMTP→ LOTM

The Location file contains the demographic data for each IHS facility. The options for managing the Location file are outlined in this section.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
          +                   Location File Menu                    +
          |                  ALBUQUERQUE HOSPITAL                   |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                          5-MAR-2002 4:07 PM


   EDLO   Location File Maintenance
   IQLO   Display Location File Entry

Select Location File Menu Option:
```

Figure 8-20: Location File Menu

8.5.1 Locations File Maintenance (EDLO)

Main Menu → TMTP→ LOTM→ EDLO

This option enables users to edit the data in the Locations file.

Step 1: Type the facility's name or ASUFAC (Area Service Unit-Facility Code) at the "Select Location to Edit:" prompt.

> **Note**: If the file already contains information for any of the following fields, it will appear between the prompt and two slashes (//). If you need to change the information, type the new data after the two slashes. If the current data is correct, just press the Return key without typing anything after the two slashes.

Step 2: Type the first line of the site's mailing address at the "Mailing Address-Street:" prompt. If the billing facility's affiliation is 638, the billing system will use the address information for that facility. Otherwise, the address will correspond to the address information specified in the Location file for the applicable Area office. (The AFFILIATION field is not editable and can only be changed by the Site Manager.)

Step 3: Type the city name of the site's mailing address at the "Mailing Address-City:" prompt.

Step 4: Type the state name of the site's mailing address at the "Mailing Address-State:" prompt.

Step 5: Type the zip code of the site's mailing address at the "Mailing Address-Zip:" prompt.

Step 6: Type the site's phone number at the "Phone:" prompt.

Step 7: Type the site's Federal tax ID number at the "Federal Tax No.:" prompt.

Step 8: Type the site's place of service code at the "Place of Service Code:" prompt. The PLACE OF SERVICE CODE field has been added to the Location file to accommodate those sites that are billing for outside locations and are also utilizing the 'USE A/R PARENT/SATELLITE' feature located in Site Parameters. The most common locations are for Home and School visits. The site may enter the appropriate Place of Service code for billing purposes.

Step 9: Type the site's bill number suffix at the "Bill Number Suffix:" prompt. The unique bill number suffix allows the site to quickly identify where the bill resides. This function will be especially useful for those sites that utilize the 'USE A/R PARENT/SATELLITE' option to bill for non-IHS locations.

Step 10: Type Y or N at the "Medicare B Only:" prompt. If the site is a freestanding clinic that can bill Medicare Part B only, you should type Y. If the site is not a freestanding clinic, type N.

> **Note**: Before your freestanding clinic site can bill Medicare Part B, you must make Medicare billable and enter address information as needed. This can be done in the Table Maintenance menu option under the Insurer Edit menu.

```
Select LOCATION to Edit: DULCE HEALTH CENTER                              ALBUQUER
QUE       JICARILLA       10

MAILING ADDRESS-STREET: PO BOX 187
MAILING ADDRESS-CITY: DULCE
MAILING ADDRESS-STATE: NEW MEXICO
MAILING ADDRESS-ZIP: 87528
PHONE: 505-753-3291
FEDERAL TAX NO.: 85-11434685// 85-0434685
MEDICARE NO.: 320057
PLACE OF SERVICE CODE: 21          INPATIENT HOSPITAL
BILL NUMBER SUFFIX: JSU
MEDICARE B ONLY: Y Yes
```

Figure 8-21: Location File Maintenance

8.5.2 Display Location File Entry (IQLO)

Main Menu → TMTP→ LOTM→ IQLO

The Display Location File Entry option enables the user to display all information for a selected facility. The Location File data cannot be edited through this option. Only those fields that contain data are displayed when using the inquiry option.

To view the Location File data for a specific facility, type the facility's name at the "Select Location:" prompt. The Location File data will appear on your screen.

```
                        *** LOCATION FILE INQUIRY ***
======================================================================
NAME: ALBUQUERQUE HOSPITAL           SHORT NAME: ALBUQUERQ HO
  AREA: ALBUQUERQUE                  SERVICE UNIT: ALBUQUERQUE
  CODE: 01                           ASUFAC INDEX: 202101
  PHONE: 505-256-4047                MAILING ADDRESS-STREET:801 Vassar NE
  MAILING ADDRESS-CITY: Albuquerque  MAILING ADDRESS-STATE: NEW MEXICO
  MAILING ADDRESS-ZIP: 87106         FINANCIAL LOCATION CODE: 001
  MEDICARE NO.: 320006               STATE: NEW MEXICO
  CURRENT TYPE: IHS                  BEGIN DATE: JAN  1, 1960
  IHS/NON-IHS: IHS FAC               AFFILIATION: IHS
  ASUFAC CODE: 202101                FACILITY TYPE: HOSPITAL
======================================================================
```

Figure 8-22: Inquire to a Location

8.6 Insurer File Menu (INTM)

Main Menu → TMTP→ INTM

The Insurer File menu enables the user to view and edit the contents of the Insurer File. The options available on the Insurer File menu are detailed in this section.

When the billing system is installed, approximately 800 insurers (complete with demographic information) are added to the Insurer file. These insurers comprise the majority of the largest insurance carriers in the nation. They do not comprise all of the nation's insurance carriers, so local adding of insurers is still necessary. When these NEW insurers are added, there is a potential for duplication with the existing insurers. If duplicate insurers are discovered, a utility exists in this system to merge them.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5                       |
          +                    Insurer File Menu                               +
          |                   ALBUQUERQUE HOSPITAL                             |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                          5-MAR-2002 4:09 PM


   EDIN   Add/Edit Insurer
   RPIN   Replacement Text for Insurer Lookups
   LSIN   Insurer Listing
   IQIN   Display Insurer Info (Inquire)
   MRIN   Merge Duplicate Insurers

Select Insurer File Menu Option:
```

Figure 8-23: Insurer File Menu

Insurer Selection

The Keyword Lookup System currently used for the ICD Diagnosis and Procedure files has also been adapted for selecting insurers. This system alters the text entered by substituting replacement text for keywords and removing conjunctive words. The text is then broken into individual words and matched against the Insurer file. Those insurers that contain all of the individual words in the Long Lookup Name field are considered hits and are displayed for selection.

```
Select INSURER: BC CA <RETURN>
( BLUE CALIFORNIA CROSS )
.
BLUE CROSS OF CALIFORNIA
- PO BOX 70000                        Domain: CA
VAN NUYS, CA 91470
```

Figure 8-24: Selecting an Insurer using Keyword Lookups

In the example in Figure 8-24, BC is replaced with BLUE CROSS and CALIFORNIA is substituted for CA. The only insurer that contained the replacement text was BLUE CROSS OF CALIFORNIA.

8.6.1 Add/Edit Insurer (EDIN)

Main Menu → TMTP→ INTM→ EDIN

This option enables users to add or edit insurers. Before adding a new insurer, make sure that the insurer does not already exist in the system.

Editing the Insurer File
Whether you are adding a new insurer or editing an existing one, the prompts that appear will be the same. The main difference between adding information to a field and editing the information already in a field is that when you are editing a field, the existing text will appear between the prompt and two slashes (//). If you wish to keep the existing text as the response to the prompt, just press the Return key without typing anything at the prompt. If you wish to change the existing data, type the new text after the two slashes (//) and it will automatically replace the existing data.

When editing an existing insurer, the user is also first prompted to screen out insurers flagged as unselectable. If the user responds YES to this question, he will not be able to edit a deactivated insurer (Figure 8-25).

```
     Select one of the following:

          1         EDIT EXISTING INSURER
          2         ADD NEW INSURER

Select DESIRED ACTION: 1// EDIT EXISTING INSURER

Screen-out Insurers with status of Unselectable? Y// ES

Select INSURER:
```

Figure 8-25: Add/Edit Insurer

To prevent the creation of duplicate records, the user should search through the existing insurers before adding a new one. If duplicates are discovered, they can be consolidated by use of the Merge Duplicate Insurers option (section 8.6.5).

> **NOTE:** The FileMan uphat-field jumping feature is not allowed when using the Add/Edit Insurer utility.

Step 1: Enter/ Update the Insurer Demographics
The first group of fields that can be edited in an existing insurers file (or responded to when adding a new insurer to the Insurer file) are related to the insurers' demographic information.

```
<--------------- MAILING ADDRESS --------------->
Street...: 123 MAIN// <Return>
City.....: ANYWHERE// <Return>
State....: NEW MEXICO// <Return>
Zip Code.: 12345// <Return>

<--------------- BILLING ADDRESS --------------->
      (if Different than Mailing Address)
Billing Office.:

Phone Number.......: (505)505-5050// <Return>
Contact Person.....: John Doe
AO Control Number..: 55387
```

Figure 8-26: Add/Edit Insurer Step 1: Insurer Demographics

Action 1: Type the street number and name of the insurer's mailing address at the "Street:" prompt. All of the mailing address fields (actions 1-4) require an entry.

Action 2: Type the city name of the insurer's mailing address at the "City:" prompt.

Action 3: Type the state name of the insurer's mailing address at the "State:" prompt.

Action 4: Type the zip code of the insurer's mailing address at the "Zip Code:" prompt.

Action 5: Type the insurer's billing address at the billing address prompts **if the billing address is different from the mailing address**. The Billing Address fields should only be entered when an insurer has a mailing address for correspondence and a billing address for bill submission. If the billing and mailing addresses are the same, just press the Return key at the "Billing Office:" prompt and continue to action 6.

Action 6: Type the insurer's phone number at the "Phone Number:" prompt.

Action 7: Type the name of the contact person for your site at the insurer's office at the "Contact Person:" prompt.

Action 8: Type the insurer's AO Control Number at the "AO Control Number:" prompt. The AO control number is used for eliminating duplicate insurers. This unique field prevents the entry of an existing control number. The value should match the number assigned to the insurer by the National Association of Insurance Commissioners (NAIC). In addition, this field is very important when sending bills electronically as it identifies the insurer. The number in this field can also be used for selecting the insurer.

Step 2: Enter/ Edit the Insurer Billing Status

The second group of fields that can be edited in an existing insurer's file (or responded to when adding a new insurer to the Insurer file) are related to the insurers.

```
Insurer Status.....: BILLABLE//
Type of Insurer....: PRIVATE INSURANCE//
All Inclusive Mode.:
Backbill Limit (months):
Dental Bill Status.: DENTAL VISITS ARE UNBILLABLE
          //
Rx Billing Status..:
ENVOY ID MEDICAL:
ENVOY ID HOSPITAL:
ENVOY ID DENTAL:

Select CLINIC UNBILLABLE:
```

Figure 8-27: Add/Edit Insurer Step 2: Billing Status

Action 1: Type Billable, Unbillable, or Unselectable at the "Insurer Status:" prompt. When the field is defined as Unbillable or Unselectable, no claims for the insurer can be created or approved. If the field is designated as Unselectable, the Patient Registration system can no longer use this insurer when adding new eligibility.

Action 2: Type the insurer's category name at the "Type of Insurer:" prompt. This category can be used as a restrictive parameter when printing bills or reports.

Action 3: Type Y or N at the "All Inclusive Mode:" prompt. This field is used to designate if an insurer is to be billed in a flat rate manner. When this field is answered yes, the user can edit the Flat Rate fields for a Visit Type and select a Prior Approval Required ICD9 code.

Action 4: Type the number of previous months that billing is allowed to occur for this insurer at the "Backbilling Limit (months):" prompt.

Action 5: Type U (Dental visits are unbillable) or O (Only Dental visits are billable) at the "Dental Bill Status:" prompt.

Action 6: Type U (medications are unbillable) or O (only outpatient drugs are billable) at the "RX Billing Status:" prompt. If you leave this field blank, all prescriptions will be considered billable. When this field is set to U (medications are unbillable), no claims for visits with a clinic of Pharmacy will be created.

Action 7: Type the insurer's Envoy-assigned Payer ID for medical claims (i.e., professional charges) at the "Envoy ID Medical:" prompt.

Action 8:Type the insurer's Envoy-assigned Payer ID for hospital claims (i.e., facility charges) at the "Envoy ID Hospital:" prompt.

Action 9: Type the Envoy-assigned Payer ID for Dental claims to the insurer at the "Envoy ID Dental:" prompt.

Action 10: Specify any additional clinic types that the insurer considered unbillable at the "Select Clinic Unbillable:" prompt.

Step 3: Enter/ Edit the Electronic Media Claims (EMC) and Plan Name
If the mode of export is UB-92-E (electronic UB-92) or HCFA-1500-E, the actions in this step are required. Without values in these fields, the entire batch of bills sent electronically will be rejected by the payor.

```
EMC SUBMITTER ID: IHSIHS
EMC PASSWORD: IHSOUT
EMC TEST INDICATOR:
USE PLAN NAME?:  YES
```

Figure 8-28: Add/Edit Insurer Step 3: EMC and Plan Name Fields

Action 1: Type the login ID assigned to your facility by the insurer at the "EMC Submitter ID:" prompt.

Action 2: Type the system password assigned to your facility by the insurer at the "EMC Password:" prompt.

Action 3: Type a T at the "EMC Test Indicator:" prompt to mark the transmission as a test transmission. If the transmission is NOT a test, leave this field blank.

Action 4: Type Y or N at the "Use Plan Name:" prompt. Typing Y instructs the system to use the plan name instead of the insurer name. Typing N or leaving the prompt blank instructs the system to use the insurer name.

Step 4: Enter/ Edit the Group Number and Provider Data

```
GROUP NUMBER: 8796

PROVIDER PIN#
Select PROVIDER: ADAM,ADAM//
  PROVIDER: ADAM,ADAM//
  PIN #: 123456//
Select PROVIDER:
```

Figure 8-29: Add/Edit Insurer Step 4: Group Number and Provider Data

Action 1:Type the group number assigned to this insurer at the "Group Number:" prompt.

Action 2: Type the name of a provider you wish to add to data for billing this insurer or type the name of a provider you wish to edit the data for at the "Select Provider:" prompt. If you do not wish to add any provider names to this insurer's file, press the Return key without typing anything at this prompt or the "Provider:" prompt (if it appears) and skip to step 5.

Action 3: Type the PIN number assigned to the provider by the insurer at the "PIN #:" prompt.

Action 4: Repeat this step until you have added all the desired provider names and PIN numbers to this insurers file.

Step 5: Enter/ Edit the Visit Type(s)
The Visit Type fields control the mode in which an insurer is billed. The visit types you can select from correspond to those contained in the Visit Type file. Visit Types can be added locally through use of the Visit Type Maintenance option (section 8.15). The visit type of claims automatically created can be Inpatient, Outpatient, or Dental, whichever is the most applicable. All claims that coincide with an established visit type entry for an insurer will be billed in the manner specified by that entry. The visit type of a claim can be changed on Page 1 (Claim Identifiers) of the Claim Editor (section 4.1.8).

```
Visit                        Mode of     Mult  Fee    ------- Flat Rate --------
Type - Description            Export     Form Sched   Start      Stop       Rate
================================================================================

Select VISIT TYPE..: 550  TEST
  Are you adding 'TEST' as a new VISIT TYPE (the 1ST for this 3P INSURER)? No//

Billable (Y/N/E)....: Y  YES
Start Billing Date (create no claims with visit date before): T  (MAR 13, 2002)
Procedure Coding....: CPT// <RETURN>
Fee Schedule........: 1          IHS 1995 STANDARD FEE SCHEDULE
Multiple Forms?.....: N  NO
Payer Assigned Provider Number.....: <RETURN>
Auto Approve?.......:N  NO
Mode of Export......: HCFA-1500-E
     1   HCFA-1500-E          Electronic HCFA-1500 (NSF Version 2.0)
     2   HCFA-1500-E ENVOY          Electronic HCFA-1500 Envoy (NSF V 2.0)
     3   HCFA-1500-E V3.01          Electronic HCFA-1500 (NSF V3.01)
     4   HCFA-1500-E V3.01          Electronic HCFA-15000 (NSF V3.01)
     5   HCFA-1500-E V3.01          Electronic HCFA-1500 (NSF V3.01)
CHOOSE 1-5: 1  HCFA-1500-E        Electronic HCFA-1500 (NSF Version 2.0)
```

Figure 8-30: Add/Edit Insurer Step 5: Standard Visit Type Fields

Action 1: Type the number that corresponds to the visit type that you wish to edit or add data to at the "Select Visit Type:" prompt. If you need to see a list of options, type two question marks (??) at the prompt first. If you are adding a new visit type to the list, type Y or N at the "Are you adding '[type name]' as a new VISIT TYPE (the #ST for this 3P INSURER)? No//" prompt.

Action 2: Type Y, N, or E at the "Billable (Y/N/E):" prompt. If the visit type is unbillable for this insurer, type N. If this visit type is billable through software other than the RPMS Third Party Billing system, type E (Billable/Billed Elsewhere). If you leave the prompt blank or type Y, the system defaults the visit type to a billable status.

Action 3: Type the date of service that the system should use as the start date for generating claims for this visit type for this insurer at the "Start Billing Date:" prompt. Typing a date at this prompt will help prevent double billing (once through RPMS and once through DDPS). If this field is populated with a valid visit date, all visits that occurred before that date will NOT have a corresponding claim.

Action 4: Type ICD9, CPT, or ADA at the "Procedure Coding:" prompt. Your entry at the "Procedure Coding:" prompt advises the computer of the proper coding method to use when creating a claim.

Action 5: Type the number of the applicable fee schedule at the "Fee Schedule?" prompt. The system uses the entry at the "Fee Schedule:" prompt to designate which fee schedule it should use when creating the claim. If this field is left blank, fee schedule 1 is used. This prompt will not appear if the Procedure Coding Method is set to ICD9 (step 5, action 4).

Action 6: Type Y or N at the "Multiple Forms:" prompt. Type Y if the insurer requires that the Professional Component be billed on a different form than the medical procedures. If the value of this field is Y, the mode of export on page 8A of the claim editor will default to the value defined in the Professional Component Visit Type.

Action 7: Type the provider number that the payor assigned to this visit type at the "Payor Assigned Provider Number:" prompt. This field should only be used if the insurer has assigned a Provider Number for this Visit Type; otherwise, leave this field blank. If a Provider Number is entered, it must be 3-13 characters long. This number is displayed on the UB-92 in block 51 or the HCFA-1500 in block 33.

Action 8: Type Y or N at the "Auto Approve?" prompt. If you type N or leave this prompt blank, the computer will assume that you **do not** want to automatically approve claims. If you type Y, when the claim generator creates a new claim for this insurer and visit type, it will examine the new claim for errors EXACTLY as it does during the claim editing process. If the new claim is found to contain no errors that would normally prevent approval (no errors with status ERROR), it will automatically approve the claim and create a bill. The bill is then ready for printing or export. Claims approved in this manner are easily identifiable as the approving official will be zero (0). This process may be desirable when trying to process a high volume of non-itemized claims for an insurer. For example, this option would allow sites to send outpatient claims to Medicare, via the RPMS Third Party Billing EMC menu, without incurring a large increase in workload of claims edit and approval in the billing office.

Caution: Exercise extreme caution with this option.

Action 9: Type the name of the billing form/ mode this insurer requires at the "Mode of Export:" prompt. If your entry matches more than one mode of export option, the system will display a list of matches. Type the number that corresponds to your desired mode of export at the "Choose 1-5:" prompt.

Selecting a mode of export determines which form will be used when the bills for this insurer are printed/exported. If you type a question mark (?) at this prompt, a list of export modes from which to choose will appear. Typing a response at this prompt only sets the default selection for this insurer; when a user is using the claim

editor, he or she has the option to manually change the mode of export for any of the pages.

Depending on your responses to specific prompts you select in the Add/ Edit Insurer option, additional prompts may appear and require responses.

If you typed Y at the "All Inclusive:" prompt (step 2, action 3), 8 new fields will appear after the "Mode of Export:" prompt. For more information on these fields, see page 8-30.

If you selected a UB-92 format (non-electronic), the "Itemized UB?" and "Select Prior Approval Required:" prompts will appear. See page 8-31 for more information on these fields.

If you select a HCFA-1500 format (non-electronic), the "Block 24K:" and "Block #33 PIN:" prompts will also appear. See page 8-31 for more information on these fields.

Additional Fields: All Inclusive (Flat Rate) Mode

```
Revenue Code........: 100//
Revenue Description.:
Bill Type...........: 111//
CPT Code............:
Select START DATE: T   MAR 13, 2002
  Are you adding 'MAR 13, 2002' as a new START DATE (the 1ST for this VISIT TYPE
)? No// Y  (Yes)
START DATE: MAR 13,2002//
RATE ($): 450.00
STOP DATE: T+90  (JUN 11, 2002)
```

Figure 8-31: Add/Edit Insurer Step 5: Additional Flat Rate Fields

The following prompts will only appear if you specified flat rate billing for this insurer by typing Y at the "All Inclusive:" prompt.

- Type the visit type's revenue code number at the "Revenue Code:" prompt. This field is mandatory if you set the export mode to UB-92 (step 5, action 9). This Revenue Code will be displayed as the single line item on the bill. The user may select the appropriate entry from the Revenue Code file. Only those Revenue Codes designated as all-inclusive codes may be selected. Revenue Codes may be edited by use of the Revenue Code Maintenance option (section 8.11.1).

- Type a brief description of the revenue code at the "Revenue Description:" prompt. This prompt will only appear if the "Revenue Code:" prompt appears. The value entered here will be displayed in block 43 of the UB-92. If you leave this field blank, the description in the Revenue Code file of the selected Revenue Code will display in block 43.

- The next 3 fields enable you to select date ranges for which a specific rate may be applicable. First, type a starting date for the date range at the "Start Date:"

prompt. This date is the visit date for which the system is allowed to start billing at a new rate. Next, type the applicable flat rate at the "Rate ($):" prompt. As these rates are updated over time, you may enter a stop date for the current rate and add a new start date with the corresponding new rate. The historical data is kept and displayed when the visit types are displayed. To add a stop date to the system, type the date at the "Stop Date:" prompt.

Additional Fields: UB-92 (paper only) Mode

```
Mode of Export......: UB-92          OMB NO. 0938-0279
Itemized UB?.....: Y  YES
```

Figure 8-32: Add/Edit Insurer Step 5: Additional UB-92 Fields

Type Y or N at the "Itemized UB?" prompt. The "Itemized UB?" prompt only appears if you specify UB-92 as the mode of export, though this prompt will not appear if the mode of export is specified as an **electronic version** of the UB-92. If you leave this prompt blank or type N, the system will prepare a non-itemized bill. If you type Y, all services will be itemized on the UB-92 at the time of billing.

Additional Fields: HCFA-1500 (paper only) Mode

```
Mode of Export......: HCFA-1500-E// HCFA-1500 Y2K        HCFA 1500 Y2K version
Block 24K...........: MD  MD PROVIDER NUMBER
Block 33 PIN#.......: ??
     Choose from:
       LOC      LOCATION CODE
       PRO      PROVIDER CODE
Block 33 PIN#.......: pro  PROVIDER CODE
```

Figure 8-33: Add/Edit Insurer Step 5: Additional HCFA-1500 Fields

The Block 24K and "Block 33 PIN#:" prompts only appear if you specify HCFA-1500 as the mode of export, though these prompts will not appear if the mode of export is specified as an **electronic version** of the HCFA-1500 form.

- Block 24K on the HCFA-1500 form is a field reserved for local use for each line item described. Type RX (RX Number) or MD (MD Provider Number) at the "Block 24K:" prompt.

- Type LOC (Location Code) or PRO (Provider Code) at the "Block 33 PIN#:" prompt. The location code is obtained from the Insurer file. (Within the Insurer file, there is a field titled 'Locations Assigned W/ PROV #'. This field needs to be populated with the facility identification number.) The provider code is obtained from the New Person file. (Within the New Person file, the field titled 'Payer Assigned Provider Number' has to be populated with the individual provider numbers.) The information in both of these items is generally populated with VA FileMan. Site Manager assistance may be needed to complete this process.

Continue adding/ editing visit types (step 5) until all of the additions/ changes have been made. When you are finished, press the Return key at the blank "Select Visit Type:" prompt and you will be returned to the Insurer File menu.

8.6.2 Replacement Text for Insurer Lookups (RPIN)

Main Menu → TMTP→ INTM→ RPIN

The Replacement Text for Insurer Lookups option enables the user to establish replacement text for use by the Insurer keyword lookup system. Keywords and the corresponding replacement text have been added for many common insurers. Thus, the use of abbreviations and acronyms when doing an insurer lookup has been enabled.

Step 1: Type the text that you wish to automatically replace at the "Select Replaced Text:" prompt.

Step 2: The system will repeat the text you just typed between the "Replaced Text:" prompt and two slashes (//). If the text is correct, press the Return key. If the text is incorrect, type the correct text at the "Replaced Text:" prompt.

Step 3: Type the text that you wish to replace the selected text with at the "Replacement:" prompt.

In the example in Figure 8-34, the text to be replaced (MH) is first entered followed by the text that will serve as its replacement (Mail Handlers). Now, whenever *MH* is entered during an insurer selection, *Mail Handlers* will be substituted for it accordingly.

```
Select REPLACED TEXT: MH  <RETURN>
  ARE YOU ADDING 'MH' AS A NEW REPLACED TEXT?  Y <RETURN>

     REPLACEMENT: MAIL HANDLERS  <RETURN>
```

Figure 8-34: Adding Replacement Text for Insurer Lookups

8.6.3 Insurer Listing (LSIN)

Main Menu → TMTP→ INTM→ LSIN

The Insurer Listing option enables users to view and/or print a list of the entries in the Insurer file. An example of this listing follows below.

Step 1: Type the name of the device you wish to print or view the list on at the "Device:" prompt.

Step 2: If the right margin of the device is different than the standard 80, type the right margin number at the "Right Margin: 80//" prompt. If the right margin is supposed to be 80 (or you are unsure of the printers margin), press the Return key at the "Right Margin: 80//" prompt to accept the default.

```
===== INSURER LISTING =====         FEB  3,2002  22:29    PAGE 1
MAILING ADDRESS                         BILLING ADDRESS
-----------------------------------------------------------------
ABINGTON COS GROUP
20.30.19.7.WASHINGTON ST
ABINGTON, MA  02351

ACCEPTANCE INS GRP
SEVENTEENTH ST #500
OMAHA, NB  68102
(402)344-8800
```

Figure 8-35: Insurer Listing Example

8.6.4 Display Insurer Info (Inquire) (IQIN)

Main Menu → TMTP→ INTM→ IQIN

The Display Insurer Info option enables the user to display all information for a selected insurer. The insurer data cannot be edited through this option. Only those fields that contain data are displayed when using the inquiry option.

To view the File data for a specific insurer, type the insurer's name at the "Select Insurer:" prompt and type Y at the "OK?" prompt, verifying the correct selection. The Insurer File Inquiry display will appear on your screen.

```
                        *** INSURER FILE INQUIRY ***

================================================================================
NAME: LINDA TEST INS                    STREET: 123 MAIN
  CITY: ANYWHERE                        STATE: NEW MEXICO
  ZIP: 12345                            PHONE: (505)505-5050
  CONTROL NUMBER: 55387                 CONTACT PERSON: John Doe
  STATUS: BILLABLE                      TYPE OF INSURER: PRIVATE INSURANCE
  ALL INCLUSIVE BILLING (Y/N): NO       BACKBILLING LIMIT (MONTHS): 3
  DENTAL BILLING STATUS: DENTAL VISITS ARE UNBILLABLE
  LONG NAME: LINDA TEST INS
CLINIC UNBILLABLE: EMERGENCY MEDICINE
CLINIC UNBILLABLE: LABORATORY SERVICES
CLINIC UNBILLABLE: PHARMACY

VISIT TYPE: TEST                        PROCEDURE CODING METHOD: CPT
  REVENUE CODE: 100                     MODE OF EXPORT: HCFA-1500 Y2K
  FEE SCHEDULE: 1                       MULTIPLE FORMS?: NO
  BILLABLE STATUS: YES                  UB92 BILL TYPE: 111
  ITEMIZED UB-92?: YES                  AUTO APPROVE?: NO
```

Figure 8-36: Insurer Inquiry Display

8.6.5 Merge Duplicate Insurers (MRIN)

Main Menu → TMTP→ INTM→ MRIN

The Merge Duplicate Insurers option enables users to merge duplicate insurers, or more precisely, the data pointers to a duplicate insurer can be redirected to point to another insurer.

Step 1: Type the name or keyword for the first insurer you wish to merge at the "Select Insurer (to Search against):" prompt. If the insurer that the system finds is the insurer you were looking for, type Y at the "OK?" prompt that will follow. If the insurer that the system finds is not the insurer that you were looking for, type N at the "OK?" prompt and repeat step 1.

Step 2: Type the name or keyword for the second insurer you wish to merge at the "Select (Search) for Duplicate Insurer:" prompt. If the insurer that the system finds is the insurer you were looking for, type Y at the "OK?" prompt that will follow. If the insurer that the system finds is not the insurer that you were looking for, type N at the "OK?" prompt and repeat step 2.

Step 3: The system will display the insurers billing information side by side. After verifying the insurers' data, type Y or N at the "Are the two Insurers duplicates (Y/N)?" prompt.

> If you type N, the system will ask if you wish to continue dup checking the first insurer. If you type Y to this prompt, repeat steps 2-3. If you type N to this prompt, repeat steps 1-3.

Step 4: The system will ask you to select the most accurate of the duplicate insurers. Type 1 or 2 (the numbers corresponding to the two insurers you are merging) at the "Which of the two is most accurate:" prompt.

Step 5: The system will merge the least accurate insurer file with the more accurate insurer file and then ask you if you wish to continue running the program. If you wish to continue merging insurers, type Y. If you are finished merging insurers, type N and you will be returned to the Insurer File menu.

```
Select INSURER (to Search against): TEST
( TEST )
.
LINDA TEST INS                          - 123 MAIN
                                          ANYWHERE, NM 12345
 OK? Y// Y

Dup-Check for: LINDA TEST INS
               123 MAIN
               ANYWHERE, NM 12345
=============================================
Select (SEARCH) for Duplicate INSURER: DEMO
( DEMO )
.
DEMO INSURER                            - 123 Main Blvd.
                                          Albuquerque, NM 87123
 OK? Y// Y
_____________________________________________________________________________
[1]  LINDA TEST INS                     | [2]  DEMO INSURER
     123 MAIN                           |      123 Main Blvd.
     ANYWHERE, NM 12345                 |      Albuquerque, NM 87123
-----------------------------------------------------------------------------

     Are the two Insurers duplicates (Y/N)? Y

     Select one of the following:

          1         LINDA TEST INS
          2         DEMO INSURER

     Which of the two is most accurate: 1  LINDA TEST INS
OK, MERGING..

Re-directing Pointers...

Do you wish to continue running this program? Y// Y
```

Figure 8-37: Merge Duplicate Insurers

8.7 Coverage Type File Menu (COTM)

Main Menu → TMTP→ COTM

Coverage Types can be established for insurers to allow the user to specify those providers, clinics and diagnosis that are unbillable based on the patient's insurance type. If a patient is linked to a particular coverage type, the ABM system will not bill the insurer for those visits that the patient's insurance type does not consider reimbursable.

```
      +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
      |          THIRD PARTY BILLING SYSTEM - VER 2.5                          |
      +                Coverage Type File Menu                                  +
      |                       SELLS HOSP                                       |
      +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
      User: DANIELSON,RODNEY                      26-MAR-91  5:02 PM

   EDCO   Add/Edit a Coverage Type
   LSCO   Print Coverage Type Listing

Select Coverage Type File Menu Option:
```

Figure 8-38: Coverage Type Menu

The Coverage Type file also enables the user to for differentiate between self and family insurance policies. Assigning a Self Only coverage type to a patient's insurance policy on file will prevent the accidental addition of further members and enable the user to manually delete any inappropriate policy members.

8.7.1 Add/Edit a Coverage Type (EDCO)

Main Menu → TMTP→ COTM→ EDCO

The ABM system is initially distributed with the coverage plans available for federal employees and Medicare's Part A and Part B plans. The coverage types initially distributed include the identifiers of the plans but do **not** include the unbillable diagnoses, clinics, dental categories, or provider disciplines for plans other than Medicare Part B. The user may add new or edit existing coverage types through this menu option.

Step 1: Type the name of the insurer you wish to add/ edit a coverage type for at the "Select INSURER:" prompt.

Step 2: Type the name of the coverage type you wish to add or edit at the "Select COVERAGE TYPE to Edit:" prompt. Each insurer may have more than one coverage type defined. If you need to see a list of existing coverage types for this insurer, type a question mark (?) at the prompt first.

If you are editing an existing coverage type, the system will repeat the coverage type name after the "NAME:" prompt. If you wish to change the coverage type name, type the text you wish to replace after the word *Replace* (following the coverage type name) and press the Return key. Type the text you wish to replace your selection with after the word W*ith* and press the Return key.

Step 3: Type the plan code value at the "Plan Code:" prompt. The plan code value must be 1-3 characters in length, or the field may be left blank. However, if the insurer you chose is Medicaid, the value of this field MUST match the value given to the coverage type in the Patient Registration system. If these two values do **NOT** match and the insurer type is Medicaid, the system will not continue checking if the claim is unbillable and the system will assume that everything is billable.

Step 4: Type S (self) or F (family) at the "Plan Type:" prompt. If this field is left unpopulated, the system defaults to self.

Step 5: Type Y or N at the "Supplemental To Medicare:" prompt. If you leave this prompt blank, the system will default to N. Type Y if the insurer is private in nature and should be billed secondary to Medicare.

Step 6: Type the name of any clinic that is considered unbillable under this coverage type at the "Select Clinics Unbillable:" prompt. This prompt (and the series of prompts that will appear if you type anything at the "Select Clinics Unbillable:" prompt) enables the user to specify a list of clinics that are unbillable for this coverage type for this insurer. You may only enter clinics that exist in the Clinic Stop file. The "Select Clinics Unbillable:" prompt will continue to appear on the screen until you press the Return key without typing a clinic name at the prompt. A clinic added to this list will remain unbillable, regardless of CPT or ICD codes, until someone deletes it from the list using the at symbol (@). You can view a list of clinics already selected as unbillable by typing a question mark (?) at a blank "Select Clinics Unbillable:" prompt. Before the system adds a clinic to or removes a clinic from the list of unbillable clinics, it will first ask you to verify your decision/ selection.

Step 7: Type the ICD9 code of any diagnosis that is considered unbillable under this coverage type at the "Select Unbillable Diagnosis (ICD9):" prompt. (The diagnosis must first exist in the ICD Diagnosis file before the user can enter it here.) The "Select Unbillable Diagnosis (ICD9):" prompt will continue to appear on the screen until you press the Return key without typing a diagnosis number at the prompt. A diagnosis entered to this list will remain unbillable until someone deletes it from the list using the at symbol (@). You can view a list of clinics already selected as unbillable by typing a question mark (?) at a blank "Select Unbillable Diagnosis (ICD9):" prompt. Before the system adds a diagnosis to or removes a diagnosis from the list of unbillable diagnoses, it will first ask you to verify your decision/ selection.

If a patient with this coverage type has at least one diagnosis that has not been selected as unbillable (regardless of whether or not they have another diagnosis that has been selected as unbillable) the entire the claim is considered billable. The patient's claim will only be flagged as unbillable (through this part of the system) if all of the diagnoses listed on the claim are currently specified as unbillable in the Unbillable Diagnoses list.

Step 8: Type the name of any provider class that is considered unbillable under this coverage type at the "Select Provider Class (Un)Billable:" prompt. You may enter any Provider Class as long as it already exists in the Provider Class file. The "Select Provider Class (Un)Billable:" prompt will continue to appear on the screen until you press the Return key without typing a Provider class name at the prompt. Each of the following prompts must contain a response for each Provider Class selected, as detailed below:

> **Action 1**: Type B (billable) or U (unbillable) at the "Billable/Unbillable:" prompt. This prompt is required. If you type U but leave the next 3 fields empty (CPT, ICD procedures and ICD diagnosis ranges), everything for the specified Provider Class is considered unbillable under this coverage type. If there are more unbillable

procedures and diagnoses for this Provider class than billable ones, you should type B at the "Billable/ Unbillable:" prompt and use the next 4 fields to specify which procedures and diagnoses are exempt from the provider class status of unbillable.

For example, if only one procedure is allowed by the coverage type for the Ambulance Driver provider class, you would type Ambulance Driver at the "Select Provider Class (Un)Billable:" prompt (step 8), type B at the "Billable/ Unbillable:" prompt (step 8, action 1), and type the only allowed CPT code at the "Select CPT Low:" and "Select CPT High:" prompts (step 8, actions 2 and 3).

This prompt must be answered in a way that requires the least amount of data entry. In our example above, it was easier to type the number for the one procedure allowed by the coverage type than to type the numbers for all of the procedures disallowed by the coverage type.

Action 2: Type the lowest CPT code in the range you specified as billable or unbillable in action 1 at the "Select CPT Low:" prompt. This prompt works in conjunction with the "Select CPT High:" prompt to establish a range of acceptable/unacceptable CPT codes for the coverage type. Through actions 2 and 3, you will specify the range of CPT codes that are either billable or unbillable, as defined in the previous prompt. The value of the "Select CPT Low:" prompt may never be greater than the value of the "Select CPT High:" prompt. If you want to enter only one CPT Code (i.e., 90010), type the same value at both the "Select CPT Low:" and "Select CPT High:" prompts.

Action 3: Type the highest CPT code in the range you specified as billable or unbillable in action 1 at the "Select CPT High:" prompt. This prompt works in conjunction with the "Select CPT Low:" prompt to establish a range of acceptable/ unacceptable CPT codes for the coverage type. Through actions 2 and 3, you will specify the range of CPT codes that are either billable or unbillable, as defined in the previous prompt. The value of the "Select CPT High:" prompt may never be lower than the value of the "Select CPT Low:" prompt. If you want to enter only one CPT Code (i.e., 90010), type the same value at both the "Select CPT Low:" and "Select CPT High:" prompts.

NOTE: More than one range is allowed for a particular provider class. The system will prompt you for and toggle between the "Select CPT Low:" and "Select CPT High:" prompts until you are finished adding ranges and you press the Return key at a blank "Select CPT Low:" prompt.

Action 4: Type the lowest ICD9 code in the range you specified as billable or unbillable in action 1 at the "Select ICD Diagnosis Low:" prompt. This prompt works in conjunction with the "Select ICD Diagnosis High:" prompt to establish a range of acceptable/unacceptable ICD9 codes for the coverage type. Through actions 4 and 5, you will specify the range of ICD9 codes that are either billable or unbillable, as defined at the "Billable/Unbillable:" prompt. The value of the "Select

ICD Diagnosis Low:" prompt may never be greater than the value of the "Select ICD Diagnosis High:" prompt. If you want to enter only one ICD9 Code (i.e., 292.81.), type the same value at both the "Select ICD Diagnosis Low:" and "Select ICD Diagnosis High:" prompts.

> **Note**: You can enter V and/or E codes at the ICD Diagnosis prompts, but if the low ICD9 code is a V code (or E code), the high ICD9 code should also be a V code (or E code).

Action 5: Type the highest ICD9 code in the range you specified as billable or unbillable in action 1 at the "Select ICD Diagnosis High:" prompt. This prompt works in conjunction with the "Select ICD Diagnosis Low:" prompt to establish a range of acceptable/unacceptable ICD9 codes for the coverage type. Through actions 4 and 5, you will specify the range of ICD9 codes that are either billable or unbillable, as defined at the "Billable/Unbillable:" prompt. The value of the "Select ICD Diagnosis High:" prompt may never be lower than the value of the "Select ICD Diagnosis Low:" prompt. If you want to enter only one ICD9 Code (i.e., 292.81.), type the same value at both the "Select ICD Diagnosis Low:" and "Select ICD Diagnosis High:" prompts.

> **Note**: You can enter V and/or E codes at the ICD Diagnosis prompts, but if the low ICD9 code is a V code (or E code), the high ICD9 code should also be a V code (or E code).

Once you have finished step 8, the "Select Prov Class (Un)Billable:" prompt will reappear. If you have an additional provider class to add to the list of unbillable provider classes for the coverage type, repeat step 8. If you are finished adding or editing provider classes considered unbillable by the coverage type, press the Return key at the blank "Select Prov Class (Un)Billable:" prompt.

```
Select INSURER: TEST
( TEST )
.
LINDA TEST INS                          - 123 MAIN
                                          ANYWHERE, NM 12345
 OK? Y//Y

Select COVERAGE TYPE to Edit: YET ANOTHER COVERAGE TYPE          LINDA TEST INS
   A     SELF

NAME: YET ANOTHER COVERAGE TYPE  Replace <RETURN>
PLAN CODE: A// <RETURN>
PLAN TYPE: SELF// F  FAMILY
SUPPLEMENTAL TO MEDICARE (Y/N): YES// <RETURN>

Select CLINICS UNBILLABLE: EMPLOYEE HEALTH UN          68
  Are you adding 'EMPLOYEE HEALTH UN' as
    a new CLINICS UNBILLABLE (the 1ST for this COVERAGE TYPE)? No// Y  (Yes)
Select CLINICS UNBILLABLE: <RETURN>
```

```
Select UNBILLABLE DIAGNOSIS (ICD9): 292.81  292.81        DRUG-INDUCED DELIRIUM
    DRUG-INDUCED DELIRIUM
         ...OK? Yes// Y  (Yes)
  Are you adding '292.81' as a new DIAGNOSIS UNBILLABLE (the 1ST for this COVERA
GE TYPE)? No// Y  (Yes)
Select UNBILLABLE DIAGNOSIS (ICD9): <RETURN>

Select PROV CLASS (UN)BILLABLE: AMBULANCE DRIVER
  Are you adding 'AMBULANCE DRIVER' as
    a new PROV CLASS (UN)BILLABLE (the 1ST for this COVERAGE TYPE)? No// Y
  (Yes)
  BILLABLE/UNBILLABLE: UNBILLABLE  UNBILLABLE
  Select CPT LOW: 90010       OFFICE/OP VISIT, NEW, LTD
         ...OK? Yes// Y  (Yes)
  Are you adding '90010' as a new CPT (the 1ST for this PROV CLASS (UN)BILLABLE)
? No// Y  (Yes)
    CPT HIGH: 90020       OFFICE/OP VISIT, NEW, COMPRH
         ...OK? Yes// Y  (Yes)
  Select CPT LOW: <RETURN>

  Select ICD PROC LOW: 12.54          TRABECULOTOMY AB EXTERNO      TRABECULOTOM
Y AB EXTERNO
         ...OK? Yes// Y  (Yes)
  Are you adding '12.54' as a new ICD PROCEDURES (the 1ST for this PROV CLASS (U
N)BILLABLE)? No// Y  (Yes)
    ICD PROC HIGH: 12.54          TRABECULOTOMY AB EXTERNO      TRABECULOTOMY AB
 EXTERNO
         ...OK? Yes// Y  (Yes)
  Select ICD PROC LOW: <RETURN>

  Select ICD DIAGNOSES LOW: 367.9  367.9        REFRACTION DISORDER NOS     UNSP
ECIFIED DISORDER OF REFRACTION AND ACCOMMODATION
         ...OK? Yes// Y  (Yes)
  Are you adding '367.9' as a new ICD DIAGNOSES (the 1ST for this PROV CLASS (UN
)BILLABLE)? No// Y  (Yes)
    ICD DIAGNOSES HIGH: 367.9  367.9        REFRACTION DISORDER NOS     UNSPECIF
IED DISORDER OF REFRACTION AND ACCOMMODATION
         ...OK? Yes// Y  (Yes)
  Select ICD DIAGNOSES LOW: <RETURN>

Select PROV CLASS (UN)BILLABLE: <RETURN>
```

Figure 8-39: Add/Edit a Coverage Type

8.7.2 Print Coverage Type Listing (LSCO)

Main Menu → TMTP→ COTM→ LSCO

This option enables the user to print a list of coverage types for all insurers currently defined in the Coverage Type file. This report sorts the insurers alphabetically and displays the coverage type name, plan code, and plan type. The coverage type data cannot be edited through this option. Only those fields that contain data are displayed when using the inquiry option.

Step 1: Type the name of the device you wish to print the file on at the "Device:" prompt.

Step 2: If the right margin of the device is different than the standard 80, type the right margin number at the "Right Margin: 80//" prompt. If the right margin is supposed to be 80 (or you are unsure of the printers margin), press the Return key at the "Right Margin: 80//" prompt to accept the default.

```
COVERAGE TYPE LIST                        MAR 26,1991  17:03    PAGE 1
                                                          PLAN  PLAN
INSURER                            NAME                   CODE  TYPE
-------------------------------------------------------------------------

AMER POSTAL WORKERS UNION          STANDARD               471   SELF
AMER POSTAL WORKERS UNION          STANDARD               472   FAMILY
GOVERNMENT EMPLOYEES HOSP ASSN     STANDARD               311   SELF
GOVERNMENT EMPLOYEES HOSP ASSN     STANDARD               312   FAMILY
```

Figure 8-40: Coverage Type Listing

8.8 Site Parameter Maintenance (SITM)

Main Menu → TMTP→ SITM

The Site Parameter Maintenance option enables users to define criteria particular to a certain site. Each parameter is fully explained in this section.

Step 1: **If your site bills insurers electronically**, type Kermit Holding File, Host File, or Mail Server at the "EMC File Preference:" prompt. (These options are defined below.) The value you enter at the "EMC File Preference:" prompt specifies the method of EMC file storage and defines to the system the type of file that must be created for electronic transfer to occur.

Kermit Holding File: This file type will create an entry in the Kermit Holding File (File #8980) for transmission to a third party via Kernel Kermit (refer to Kernel documentation).

Host File: This file type will create a host file containing third party claims in the format specified for the insurer and visit type. This is the most common method.

Mail Server: This file type will generate a network mail message containing claim information for transmission to the IHS or other clearinghouse.

NOTE: The IHS Clearinghouse is no longer supported.

If your site does not bill insurers electronically, press the Return key at the blank "EMC File Preference:" prompt.

Step 2: Type a file path name at the "Default EMC Path:" prompt. This prompt should only be answered if your site performs electronic billing through this system and users are

allowed to specify the default directory where the electronic host file is stored. You will probably need to enter a UNIX directory (i.e., /usr/spool/uucppublic/), although DOS directory names are also allowed.

> **NOTE:** You only need to answer the step 1 and step 2 prompts if your site bills insurers electronically.

Step 3: Type the name of a facility that receives payments for services rendered at this site at the "Facility To Receive Payments:" prompt. This value will be used to determine the payment address and Federal Tax Number.

> **NOTE:** The payment address and Federal Tax Number are obtained from the Location file for the facility specified.

Step 4: Type the name of the facility you selected in Step 3 as it will be printed on the bill at the "Printable Name Of Payment Site:" prompt.

Step 5: Type the name/ number of your site's current fee schedule at the "Current Default Fee Schedule:" prompt. The fee schedule you indicate at this prompt will be used in itemized billing for those insurers who do not require the use of their own Fee Schedule. You may select any fee schedule that has already been defined through the Fee Schedule Table Maintenance option (section 8.2.1). If you need to see a list of available fee schedules, type two question marks (??) at the prompt first.

Step 6: Type Y or N at the "Create Bill For All Patients:" prompt. Type Y if you want the system to create a claim/bill for every visit, whether the patient has third party eligibility or is an Indian Beneficiary. Printing a claim/bill for every visit (regardless of insurance coverage) can help with reporting on the cost of every patient encounter.

Step 7: Type Y or N at the "Require That Queuing Be Forced:" prompt. Type Y to automatically queue all print jobs that have been sent to a system printer. If you leave this prompt blank, the system will default to a No response.

Step 8: Type Y or N at the "Display Long ICD/CPT Description:" prompt. Type Y to make the system display the extended description of the ICD or CPT narrative. If you leave this prompt blank, the system will default to a No response.

Step 9: Type a number between 0 and 99 at the "Backbilling Limit (Months):" prompt. The number you enter is the number of months users are allowed to go back in time for billing. This field is required.

Step 10: Type Attending/Operating Providers, Approving Official, or New Person at the "Block 31 (HCFA-1500) Print:" prompt. Your response to this prompt specifies what information will appear in Block 31 on the HCFA-1500 form.

Associated titles will also be printed.

Step 11: Type the name of the person at the "HCFA-1500 Signature:" prompt. The name is usually that of the attending physician, but you may choose from any name that already exists in the New Person file. The entered value is printed in the signature box at the bottom of the HCFA-1500 form.

Step 12: Type the name of the person at the "UB-92 SIGNATURE:" prompt. The name is usually that of the attending physician, but you may choose from any name that already exists in the New Person file. The entered value is printed in the signature box of the UB-92 form.

Step 13: Type the value from the 3P Code file that corresponds to the billing facility at the "Place Of Service Code:" prompt. This value is printed in the Place of Service box on the HCFA-1500 form. If you need to see a list of available options, type a question mark (?) at the prompt first.

Step 14: Type File, 9-Track Tape, Floppy Disk, or Cartridge Tape at the "Mode Of Export To Area Office:" prompt. The mode type you enter at this prompt will determine the method the system uses to export data to the Area Office Tracking system.

Step 15: Type up to four characters that may be used to identify the facility that produced the bill at the "Bill Number Suffix (FAC-Code):" prompt. If this field is populated, the value will be appended to the bill number for all bills generated. This is especially helpful when a site does billing for more than one facility. If the prompt is left blank, the system will not append a value to the bill number.

Step 16: Type Y or N at the "Append HRN To Bill Number:" prompt. Type Y if you want patient Health Record Numbers to be appended to the bill number. If you leave this field blank, the system will default to a No response.

Step 17: Type Y or N at the "ALLOW FOR CPT MODIFIERS PROMPT:" prompt. The value in this field determines whether or not a modifier can be designated for a CPT procedure. If you type Y, users will be prompted for a modifier when adding or editing a CPT procedure.

Step 18: Type Y or N at the "Set Prof. Comp. Automatically:" prompt. If you type N, the minimal level of service will not automatically be set in the Medical page (8A) when the attending provider is a physician.

Step 19: Type a number between 1 and 730 at the "Days Inactive Before Purging:" prompt. This number represents the number of days a claim is allowed to remain inactive before being automatically purged by the Claim Generator.

```
EMC File Preference.............: HOST FILE// <RETURN>
DEFAULT EMC PATH................: /usr/spool/uucppublic/
          Replace <RETURN>
Facility to Receive Payments....: ALBUQUERQUE ADMINISTRATION
         // <RETURN>
Printable Name of Payment Site..: DULCE HEALTH CENTER
         // <RETURN>
Current Default Fee Schedule....: 1// <RETURN>
Create Bills for all Patients...: NO// <RETURN>
Require that Queing be Forced...: YES// <RETURN>
Display Long ICD/CPT Description: NO// <RETURN>
Backbilling Limit (months)......: 48// <RETURN>
Block 31 (HCFA 1500) print......: ATTENDING/OPERATING PROVIDERS
         //
HCFA-1500 SIGNATURE.............: ADAM,ADAM
UB-92 SIGNATURE.................: ADAM,ADAM
Place of Service Code...........: 21//<RETURN>
Mode of Export to Area Office...:
Bill Number Suffix (fac-code)...: JSU// <RETURN>
Append HRN to Bill Number.......: NO//<RETURN>
Allow for CPT Modifiers Prompt..: YES//<RETURN>
Set Prof. Comp. Automatically...: YES//<RETURN>
Days Inactive before Purging....: 730//<RETURN>
```

Figure 8-41: Site Parameter Maintenance Steps 1-19

Step 20: Type the name of the HCFA-1500 form that you wish to use as the default for your facility at the "Default Version Of HCFA-1500:" prompt. This setting will only affect claims with the HCFA-1500 mode of export. Currently there are 3 versions of the HCFA-1500 form that you can select from (1984, 1990, or 1998 version), but the most widely accepted is the 1998 (Y2K) version.

Step 21: Type the name of the form you wish to use as the default mode of export for dental billing at the "Default Form For Dental Billing:" prompt. If you need to see a list of options, type a question mark (?) at the prompt first. The ADA-94 form is becoming the most popular.

> **Note**: The ADA-94 and ADA-99 Dental forms (box 40) have been changed to print the address of service (not payment) as well as allowing cities with spaces in their names to print properly. This change was made assuming that the following is true:
>
> The Visit Location in the Location File retains their physical or mailing address.
>
> There is a separate Location set up in Site Parameters to specify the name of the facility to receive payments.

Step 22: Type the name(s) of any clinics that that the facility always considered unbillable, regardless of insurer or coverage, at the "Select Default Unbillable Clinics:" prompt. The "Select Default Unbillable Clinics:" prompt will continue to appear on the screen, giving you the opportunity to list more than one clinic, until you press the Return key without

typing a clinic name at the prompt. If you do not wish to specify any clinics as unbillable, just press the Return key at the first "Select Default Unbillable Clinics:" prompt.

Step 23: Type the name(s) of any provider disciplines that that the facility always considered unbillable, regardless of insurer or coverage, at the "Select Dflt Invalid Prv Disciplines:" prompt. The "Select Dflt Invalid Prv Disciplines:" prompt will continue to appear on the screen, giving you the opportunity to list more than one provider discipline, until you press the Return key without typing a provider discipline at the prompt. If you do not wish to specify any disciplines as unbillable, just press the Return key at the first "Select Dflt Invalid Prv Disciplines:" prompt.

Step 24: Type Policy Holder, Insurer Address, or Blank at the "UB-92 Form Locator 38" prompt. This prompt allows the user to specify what data should be populated on the UB 92 claim form in box 38. If you choose to leave this prompt unanswered, the system will default to the Blank response.

Step 25: Type a number between 3 and 180 at the "Orphan Visit Lag Time (Days)" prompt. This setting relates to lab (radiology, pharmacy, or any other) visits being entered before (or even without) a doctor visit, thus creating an orphan. If PCC requires up to three days to enter doctor visits, the number 3 should be entered here. Thus, the computer will wait three days before creating a claim for the lab visits with the expectation that the doctor visit was entered in the meantime. In that case, the lab visit would be linked to the doctor visit and the orphan would no longer exist. If the field is left blank, the Claim Generator will wait seven days before creating a claim.

Step 26: Type Y or N at the "USE A/R PARENT SATELLITE SET-UP:" prompt. Type Y to indicate that your facility may bill for services performed at a location outside the primary facility. This does not include locations (satellites) that are already set up. Type N to indicate that your facility does not allow for multiple location billing.

Step 27: Type Y or N at the "Medicare Part B Only:" prompt. Type Y if your site only bills Part B claims to Medicare.

Step 28: Type 0, S, or D at the "Default Dental Code Prefix:" prompt. If you do not wish to enter a default dental code prefix, press the Return key at the blank prompt.

Step 29: Type a price that corresponds to each of the seven dispense fee categories listed below at the corresponding prompts. Type the price in whole dollar amounts (e.g., type 5 for $5.00).

- OP Prescription DISPENSE FEE
- IV Admixture DISPENSE FEE
- IV Piggyback DISPENSE FEE
- IV Hyperal DISPENSE FEE

- IV Syringe DISPENSE FEE
- IV Chemotherapy DISPENSE FEE
- Inpatient Rx DISPENSE FEE

```
Default Version of HCFA-1500....: New Version dated 12-90
         // 3  Y2K Version dated 10-98
Default Form for Dental Billing.: ADA-94// <RETURN>
Select DEFAULT UNBILLABLE CLINICS: <RETURN>
Select DFLT INVALID PRV DISCIPLINES: ADMINISTRATION
         // <RETURN>
Select DISPLAY UNBILLABLE INSURER(S): NEW MEXICO MEDICAID
         //<RETURN>
UB-92 Form Locator 38: I    INSURER ADDRESS
ORPHAN VISIT LAG TIME (DAYS)....: 30// <RETURN>
USE A/R PARENT SATELLITE SET-UP?: YES// <RETURN>
MEDICARE PART B ONLY?...........: <RETURN>
DEFAULT DENTAL CODE PREFIX......: D// <RETURN>

RX DISPENSE FEES
================
OP Prescription Dispense Fee....: 5//<RETURN>
IV Admixture Dispense Fee.......: 10//<RETURN>
IV Piggyback Dispense Fee.......: 10//<RETURN>
IV Hyperal Dispense Fee.........: 10//<RETURN>
IV Syringe Dispense Fee.........: 8//<RETURN>
IV Chemotherapy Dispense Fee....: 10//<RETURN>
Inpatient RX Dispense Fee.......: 5//<RETURN>
```

Figure 8-42: Site Parameter Maintenance Steps 20-29

Step 30: Type the number that corresponds to a Claim Editor page at the "Select Claim Page(s) to Be Skipped:" prompt. This option allows the user to skip certain pages in the Claim Editor. Your choices include: 1 (Surgery), 2 (Revenue Code), 3 (Laboratory), 4 (Radiology), 5 (Anesthesia), 6 (Pharmacy), 7 (Dental), 8 (Misc. Services), and 9 (Supplies).

For example, if your facility never performs surgeries, there would be no reason for the page that indicates surgery to be displayed in the Claim Editor. You would type 1 at the "Select Claim Page(s) to Be Skipped:" prompt to force the system to skip the Surgery page.

The "Select Claim Page(s) to Be Skipped:" prompt will reappear, giving you the opportunity to select more than one page, until you press the Return key at a blank "Select Claim Page(s) to Be Skipped:" prompt. If you do not wish to skip any pages in the Claim Editor, press the Return key at the first "Select Claim Page(s) to Be Skipped:" prompt.

Step 31: Type Y or N at the "Edit:" prompt associated with the Page 9 Remarks field. The system will display the current Page 9 Remarks value before prompting you to edit it. If you wish to edit the text, type Y. If the text displayed on your screen is correct, type N.

The text that you enter (or accept) at this prompt will be used as the default value for the Remarks box on the UB-92 form. This text will only be set as the default value and the user

will have the opportunity to add claim-specific remarks to this value through Page 9F of the Claim Editor.

Step 32: Type the letter that corresponds to the insurance type you wish to export to the Area office at the "Enter Response:" prompt. The "Enter Response:" prompt will continue to reappear, giving you an opportunity to enter more than one insurance type, until you press the Return key at a blank "Enter Response:" prompt or until you use the X option.

All selected insurance types will appear next to the "Selected:" prompt above the list of options. If you wish to remove all of the previously selected options, type X at the "Enter Response:" prompt.

```
Select CLAIM PAGE(s) TO BE SKIPPED: <RETURN>
PAGE 9 REMARKS:
Send Payment to Provider (see Block 1)

  Edit? NO// <RETURN>
Select Insurance Types to Export to Area Office

Selected:

     Select one of the following:

          H         HMO
          M         MEDICARE SUPPL.
          D         MEDICAID FI
          R         MEDICARE FI
          P         PRIVATE INSURANCE
          W         WORKMEN'S COMP.
          C         CHAMPUS
          F         FRATERNAL ORGANIZATION
          N         NON-BENEFICIARY (NON-INDIAN)
          I         INDIAN PATIENT
          K         CHIP

          X         DELETE

Enter response: R
```

Figure 8-43: Site Parameter Maintenance Steps 30-32

8.9 Error Codes Menu (ERTM)

Main Menu → TMTP→ ERTM

The Error Codes Menu enables users to edit error codes and create a listing of error codes. These options are outlined in this section.

The Error Code file allows users to designating whether a problem condition is considered an error or a warning. It also contains text explaining the corrective action necessary for

resolving an error. If a condition is designated as an error, no claims containing this condition can be approved for billing.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5                          |
          +                    Error Codes Menu                                   +
          |                  ALBUQUERQUE HOSPITAL                                  |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                            5-MAR-2002 5:01 PM


   EDER   Edit Error Codes
   LSER   Error Codes Listing

Select Error Codes Menu Option:
```

Figure 8-44: Error Codes Menu

8.9.1 Edit Error Codes (EDER)

Main Menu → TMTP→ ERTM→ EDER

The Edit Error Codes option enables users to edit the error/warning status of problem conditions.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |                    ABM SYSTEM - VER 2.5                                |
          +                     Edit Error Codes                                   +
          |                        SELLS HOSP                                      |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: MAROFSKY,SANDRA                      17-APR-1997 3:38 PM

Select 3P ERROR CODE: 5  INSURER ASSIGNED PROVIDER NUMBER UNSPECIFIED
ERROR STATUS: WARNING//
DISPLAY ONLY WHEN IN ERROR:
Select REQUIRED BY INSURER: MEDICARE//
Select REQD FOR EXPORT FORM:
```

Figure 8-45: Edit Error Codes

Step 1: Select an error code to edit by typing the error code number (or a word contained in the error description) at the "Select 3P Error Code:" prompt.

> **Note**: Some error codes cannot be edited locally. To see a list of error codes that **can** be edited, type two question marks at the "Select 3P Error Code:" prompt.

Step 2: Type E (error) or W (warning) at the "Error Status:" prompt to set the error code's status. If you type E, a claim that this error code appears on cannot be approved until the error is fixed. If you type W, a message will appear on the claim but it still may be approved.

> **Note**: If the error is only specific to a handful of insurers, type W at the "Error Status:" prompt.

Step 3: Type Y or N at the "Display Only When In Error:" prompt. If you type Y, the Claim Editor will not display the problem condition when it is a warning.

Step 4: If the error/warning code only applies to a specific insurer, type the insurer's name at the "Required by Insurer:" prompt. This prompt will continue to appear, allowing you to enter more than one insurer's name, until you press the Return key at a blank "Required by Insurer:" prompt. If you do not wish to specify specific insurers, press the Return key at the first "Required by Insurer:" prompt.

> **Note**: If the error/ warning is applicable to all insurers (such as the PATIENT NAME UNSPECIFIED error), leave the "Required by Insurer:" prompt blank.

Step 5: If the error/ warning code only applies to a specific form (mode of export), type the form name at the "Reqd for Export Form:" prompt. This prompt will continue to appear, allowing you to enter more than one form/ mode name, until you press the Return key at a blank "Reqd for Export Form:" prompt. If you do not wish to specify specific forms/ modes of export, press the Return key at the first "Reqd for Export Form:" prompt.

> **Note**: If the error/ warning is applicable to all forms or modes of export (such as the PATIENT NAME UNSPECIFIED error), leave the "Reqd for Export Form:" prompt blank.

8.9.2 Error Codes Listing (LSER)

Main Menu → TMTP→ ERTM→ LSER

A listing of all Error Conditions can be displayed by use of the Error Codes Listing Menu option. To view/print a list of errors and warnings, type the name of the device you wish to print the list on at the "Device:" prompt. A sample list is included in Figure 8-46.

```
     ERROR CODE LIST: ALBUQUERQ HO                                    Page: 1

E#    STATUS    NARRATIVE
================================================================================
001   ERROR     OPERATIVE PROVIDER ENTERED WITH NO SURGICAL PROCEDURES
002   ERROR     SURGICAL PROCEDURE ENTERED BUT OPERATING PROVIDER IS NOT
003   ERROR     OPERATIVE PROVIDER ENTERED WITH NO ICD PROCEDURES
004   ERROR     CLAIM HAS NO CHARGES (PROCEDURES OR SERVICES) TO BILL
005   WARNING   INSURER ASSIGNED PROVIDER NUMBER UNSPECIFIED
006   ERROR     FEDERAL TAX NUMBER (EIN) UNSPECIFIED
007   WARNING   PROSTHETIC DEVICE CHARGE NOT ENTERED FOR THE INTRAOCULAR LENSE
008   ERROR     FACILITY THAT IS TO RECEIVE PAYMENTS IS NOT ESTABLISHED
010   ERROR     PATIENT NAME UNSPECIFIED
011   WARNING   PATIENT ADDRESS UNSPECIFIED
012   ERROR     PATIENT DATE OF BIRTH UNSPECIFIED
013   ERROR     PATIENT SEX UNSPECIFIED
014   WARNING   PATIENT MARITAL STATUS UNSPECIFIED
015   ERROR     ADMISSION DATE UNSPECIFIED

Enter RETURN to continue or '^' to exit:
```

Figure 8-46: Error Code Listing

8.10 Group Insurance Plans Menu (GRTM)

Main Menu → TMTP→ GRTM

The Group Insurance Plans menu enables users to edit, list, assign, and merge group plans in the ABM system. These options are outlined in this section.

```
   +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
   |          THIRD PARTY BILLING SYSTEM - VER 2.5                          |
   +               GROUP INSURANCE PLANS MENU                               +
   |                       SELLS HOSP                                       |
   +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
USER: DANIELSON,RODNEY                3-APR-1991 10:32 PM

   EDGR   ADD/EDIT GROUP INSURANCE PLANS
   LSGR   GROUP INSURANCE PLANS LISTING
   ASGR   MASS GROUP PLAN ASSIGNMENT FOR SPECIFIED EMPLOYER
   MRGR   MERGE DUPLICATE GROUP PLANS

SELECT GROUP INSURANCE PLANS MENU OPTION:
```

Figure 8-47: Group Insurance Plans Menu

8.10.1 Add/Edit Group Insurance Plans (EDGR)

Main Menu → TMTP→ GRTM→ EDGR

The EDGR option enables users to add and edit group insurance plans in the ABM system. If a patient is a member of a group plan, the system needs the group name and numbers for that plan to automate the billing process.

Although the user is given the ability to add new group plans, users should make sure that the plan they wish to add does not already exist in the ABM system, preventing duplication.

The process for adding a group plan and the process for editing a group plan are similar enough that they will be presented together in this section. The main difference between adding and editing is that, when editing a group plan, any data that has already been entered at the prompts will appear between the prompt and two slashes (//). If the user wishes to keep the existing data, he or she just needs to press the Return key after the two slashes. If the user wishes to edit the existing data, he or she must type the new data after the two slashes.

Step 1: Type the name of the group plan that you wish to add/ edit at the "Select Employer Group Insurance Group Name:" prompt. If you are adding a new group plan, the system will ask you to verify your addition. Because the group plan is new, skip to step 3.

Step 2: If you wish to edit the name of the group plan, type the new name at the "Modify Group Name (if desired):" prompt. If you do not want to edit the group plan name, press the Return key at the blank "Modify Group Name (if desired): prompt.

Step 3: Type Y or N at the "Do the Group Numbers vary depending on Visit Type (Y/N)?" prompt. If the group number is the same, regardless of the patient's visit type, type N and continue to step 4a. If the group number changes depending on the patient's type of visit (inpatient, outpatient, dental), type Y and continue to step 4b.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |          THIRD PARTY BILLING SYSTEM - VER 2.5                              |
           +             Add/Edit Group Insurance Plans                                 +
           |                  ALBUQUERQUE HOSPITAL                                      |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: CHAPEK,JADE                          15-MAR-2002 11:38 AM

Select EMPLOYER GROUP INSURANCE GROUP NAME: TEST GROUP

Modify GROUP NAME (if Desired): TEST GROUP// TEST GROUP PLAN
```

Figure 8-48: Add/Edit Group Insurance Plans, Steps 1-3

Step 4a: Type the group number for the group plan at the "[5a] Group Number:" prompt. This number must be 3 to 17 characters long and correspond to the group number assigned to the group plan by the insurer. Once you have entered the Group Number, you will be automatically returned to the Group Insurance Plan menu.

```
     NOTE: Some Insurers assign different Group Numbers based upon the
           particular type of visit (dental, outpatient, etc.) that
           occurred.

Do the Group Numbers vary depending on Visit Type (Y/N)? Y// NO

[5a] Group Number.....: 12345
```

Figure 8-49: Add/Edit Group Insurance Plans, Step 4a

Step 4b: Type 111 (inpatient), 131 (outpatient), or 998 (Dental) at the "Select Visit Type:" prompt. This prompt will reappear after you have specified the group number for the selected visit type so that you can enter group numbers for any other visit types that apply. The system will ask you to verify your selection before you can continue to step 5.

Step 5: Type the group plan number associated with the visit type you selected in step 4b at the "Group Number (Visit Specific):" prompt. This number must be 3 to 17 characters long and correspond to the group number assigned to the group plan by the insurer.

Step 6: Another "Select Visit Type:" prompt will appear. Repeat steps 4b-6 to add group numbers for additional visit types or press the Return key to return to the Group Insurance Plan menu.

```
     NOTE: Some Insurers assign different Group Numbers based upon the
           particular type of visit (dental, outpatient, etc.) that
           occurred.

Do the Group Numbers vary depending on Visit Type (Y/N)? N// Y  YES

Select VISIT TYPE: 111  (INPATIENT)
  Are you adding 'INPATIENT' as a new VISIT TYPE (the 1ST for this EMPLOYER GROU
P INSURANCE)? No// Y  (Yes)
  GROUP NUMBER (VISIT SPECIFIC): 12345A
Select VISIT TYPE: 131  (OUTPATIENT)
  Are you adding 'OUTPATIENT' as a new VISIT TYPE (the 2ND for this EMPLOYER GRO
UP INSURANCE)? No// Y  (Yes)
  GROUP NUMBER (VISIT SPECIFIC): 12345B
Select VISIT TYPE: <Return>
```

Figure 8-50: Add/Edit Group Insurance Plans, Steps 4b

8.10.2 Group Insurance Plans Listing (LSGR)

Main Menu → TMTP→ GRTM→ LSGR

This option enables the user to view/print a current listing of Group Insurance Group Numbers.

Step 1: Type the name of the device you wish to print the file on at the "Device:" prompt.

Step 2: If the right margin of the device is different than the standard 80, type the right margin number at the "Right Margin: 80//" prompt. If the right margin is supposed to be 80

(or you are unsure of the printers margin), press the Return key at the "Right Margin: 80//" prompt to accept the default.

```
GROUP INSURANCE PLAN LIST                      SEP 18,1997  12:11    PAGE 1
                                                             VISIT SPECIFIC
GROUP NAME                      GROUP NUMBER     VISIT TYPE  GROUP NUMBERS
------------------------------------------------------------------------------
ALG GROUP                                        OUTPATIENT  4445566
DELTA GRP                       3244-342
FAA                             74238974
FAA                             293432-A
FORD MTR GRP                    2999993-2
JICARILLA APACHE TRIBE          88262-A2         OUTPATIENT  889-0-72162

Enter RETURN to continue or '^' to exit:
```

Figure 8-51: Group Insurance Plans Listing

8.10.3 Mass Group Plan Assignment for Specified Employer (ASGR)

Main Menu → TMTP→ GRTM→ ASGR

This option allows the mass assignment of a specified Group Plan to the policies of each employee for a selected employer.

Step 1: Type Y or N at the "Do you wish to run this utility program?" prompt. If you type N, the system will return you to the Group Insurance Plans menu.

Step 2: Type the name of the employer whose employees you wish to assign the group plan to at the "Select EMPLOYER:" prompt. You can select any employer currently in the Employer file.

Step 3: Type the name of the Group Plan that will be assigned to all employees of employer you specified in step 2 at the "Select GROUP PLAN:" prompt. You may select from any Group Plan already in the Group Plan file.

Step 4: The computer will display what you have selected and ask you to verify your selection. Type Y or N at the "Is this Correct (Y/N)?" prompt. If you type Y, the system will change the policies you've selected and display a count of the policies changed. If you type N, the system will not change the policies but will take you to step 5.

Step 5: Type Y or N at the "Do you wish to Select another Employer?" prompt. If you type N, the system will return you to the Group Plan menu. If you type Y, the "Select EMPLOYER:" prompt will reappear. Repeat steps 1-5.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
          +   Mass Group Plan Assignment for specified Employer     +
          |                  ALBUQUERQUE HOSPITAL                   |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                        15-MAR-2002 2:07 PM

This utility allows for the mass assignment of a specified Group Plan to the
policies of each employee for a selected Employer.

Do you wish to run this utility program? YES

Select EMPLOYER: TEST

Select GROUP PLAN: TEST GROUP PLAN

You have selected to assign all employees of: TEST
                              the Group Plan: TEST GROUP PLAN

Is this Correct (Y/N)? Y   YES..

          POLICIES CHANGED: 1


Do you wish to Select another Employer? N
```

Figure 8-52: Mass Group Plan Assignment for Specified Employer

8.10.4 Merge Duplicate Group Plans (MRGR)

Main Menu → TMTP→ GRTM→ MRGR

This option enables the user to merge duplicate Group Plans together.

Step 1: Type the name or keyword for the first insurer you wish to merge at the "Select GROUP PLAN (to Search against):" prompt. If the group plan that the system finds is the plan you were looking for, type Y at the "OK?" prompt that will follow. If the group plan that the system finds is not the plan that you were looking for, type N at the "OK?" prompt and repeat step 1.

Step 2: Type the name or keyword for the second group plan you wish to merge at the "Select (SEARCH) for Duplicate GROUP PLAN:" prompt. If the group plan that the system finds is the plan you were looking for, type Y at the "OK?" prompt that will follow. If the group plan that the system finds is not the plan that you were looking for, type N at the "OK?" prompt and repeat step 2.

Step 3: The system will display the group plans information side by side. After verifying the plan data, type Y or N at the "Are the two GROUP PLANS duplicates (Y/N)?" prompt.

> If you type N, the system will ask if you wish to continue dup checking the first group plan. If you type Y to this prompt, repeat steps 2-3. If you type N to this prompt, repeat steps 1-3.

Step 4: The system will ask you to select the most accurate of the duplicate group plans. Type 1 or 2 (the numbers corresponding to the two group plans you are merging) at the "Which of the two is most accurate:" prompt.

Step 5: The system will merge the least accurate group plan file with the more accurate group plan file and then ask you if you wish to continue running the program. If you wish to continue merging group plans, type Y. If you are finished merging group plans, type N and you will be returned to the Group Plan menu.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |          THIRD PARTY BILLING SYSTEM - VER 2.5                              |
           +              Merge Duplicate Group Plans                                   +
           |                  ALBUQUERQUE HOSPITAL                                      |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: CHAPEK,JADE                          15-MAR-2002 2:11 PM

Select GROUP PLAN (to Search against): TEST
     1   TEST GROUP PLAN
     2   TEST PLAN
CHOOSE 1-2: 1  TEST GROUP PLAN

Dup-Check for: TEST GROUP PLAN
               33456
================================================
Select (SEARCH) for Duplicate GROUP PLAN: TEST PLAN
_____________________________________________________________________________________
[1]  TEST GROUP PLAN                    | [2]  TEST PLAN
     33456                              |      12345
-------------------------------------------------------------------------------------

     Are the two GROUP PLANS duplicates (Y/N)? YES


     Select one of the following:

          1         TEST GROUP PLAN
          2         TEST PLAN

     Which of the two is most accurate: 1  TEST GROUP PLAN

Re-directing Pointers...


Do you wish to continue running this program? Y// N
```

Figure 8-53: Merge Duplicate Group Plans

8.11 Revenue Codes Menu (RVTM)

Main Menu → TMTP→ RVTM

The Error Codes Menu enables users to maintain revenue codes and create a listing of revenue codes. These options are outlined in this section.

```
      +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
      |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
      +                   Revenue Codes Menu                    +
      |                       SELLS HOSP                        |
      +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+

   EDRV   Revenue Code Maintenance
   LSRV   Print Revenue Code Listing

Select Revenue Codes Menu Option:
```

Figure 8-54: Revenue Codes Menu

8.11.1 Revenue Codes Maintenance (EDRV)

Main Menu → TMTP→ RVTM→ EDRV

The Revenue Codes Maintenance option enables users to make a small number of changes to revenue codes used in the ABM system.

Step 1: Type the revenue code name or number at the "Select Revenue Code to Edit:" prompt.

Step 2: Type A (activate) or I (inactivate) at the "Activate/Inactivate Code:" prompt. Type I if you don't want the revenue code to be selected through the Claim Editor.

Step 3: Type Y or N at the "All Inclusive Rate (Y/N):" prompt. Type Y if you want the revenue code to be selectable in the Insurer file's visit type fields.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
           +                Revenue Code Maintenance                 +
           |                  ALBUQUERQUE HOSPITAL                   |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: CHAPEK,JADE                        15-MAR-2002 2:50 PM


Select REVENUE CODE to Edit: 918        PSYCH/TESTING      TESTING

Activate/Inactivate Code..: A  ACTIVATE CODE
All Inclusive Rate (Y/N)..: Y  YES


Select REVENUE CODE to Edit:
```

Figure 8-55: Revenue Code Maintenance

8.11.2 Print Revenue Code Listing (LSRV)

Main Menu → TMTP→ RVTM→ LSRV

The Print Revenue Code Listing option enables the user to view or print a list of the current revenue codes. This report also lists the standard abbreviated description, active status, and all-inclusive status for each revenue code.

Step 1: Type the name of the device you wish to print the file on at the "Device:" prompt.

Step 2: If the right margin of the device is different than the standard 80, type the right margin number at the "Right Margin: 80//" prompt. If the right margin is supposed to be 80 (or you are unsure of the printers margin), press the Return key at the "Right Margin: 80//" prompt to accept the default.

```
REVENUE CODES LIST
REVENUE                                                          ALL
CODE     STANDARD ABBREVIATION                 INACTIVATE       INCLUSIVE
-------------------------------------------------------------------------

100      ALL INCL R&B/ANC                      ACTIVATE CODE    YES
101      ALL INCL R&B                          ACTIVATE CODE    YES
110      ROOM-BOARD/PVT
111      MED-SUR-GY/PVT
112      OB/PVT
113      PEDS/PVT
114      PSYCH/PVT
115      HOSPICE/PVT
116      DETOX/PVT
117      ONCOLOGY/PVT
118      REHAB/PVT
118      REHAB/PVT
119      OTHER/PVT
120      ROOM-BOARD/SEMI
MED-SURG-GYN/2BED
```

Figure 8-56: Print Revenue Code Listing

8.12 UB-92 Codes Menu (UCTM)

Main Menu → TMTP→ UCTM

The UB-92 Codes menu enables users to maintain and list the UB-92 codes. These options are outlined in this section.

```
  +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
  |          THIRD PARTY BILLING SYSTEM - VER 2.5                      |
  +                    UB-92 Codes Menu                               +
  |                       SELLS HOSP                                   |
  +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+

   EDUB   UB-92 Code Maintenance
   LSUB   UB-92 Codes Listing

Select UB-92 Codes Menu Option:
```

Figure 8-57: UB-92 Codes Menu

8.12.1 UB-92 Code Maintenance (EDUB)

Main Menu → TMTP→ UCTM→ EDUB

The UB-92 maintenance function enables the user to add a new code or edit an existing code.

The process for adding a UB-92 code and the process for editing a UB-92 code are similar enough that they will be presented together in this section. The main difference between adding and editing is that, when editing a UB-92 code, any data that has already been entered at the prompts will appear between the prompt and two slashes (//). If the user wishes to keep the existing data, he or she just needs to press the Return key after the two slashes. If the user wishes to edit the existing data, he or she must type the new data after the two slashes.

Step 1: Prior to editing a code, you must first specify the corresponding category code. Type the number that corresponds to the category code for which you wish to edit a code at the "Select Desired Code:" prompt.

Step 2: Type 1 (Edit), 2 (Add), or 3 (Quit) at the "Desired action:" prompt. If you wish to edit a code in the selected code category, type 1. If you wish to add a new code to the selected code category, type 2. If you do not wish to alter the selected code category at all, type 3 and you will be returned to the UB-92 Codes menu.

> **Note**: Codes may be added if necessary; however, caution should be taken to ensure that the code to be added is legitimate and known by the entities to be billed.

Step 3: Type the number of the code that you wish to edit at the "Select [category name] code to Edit:" prompt. If you need to see a list of options, type two question marks (??) at the prompt first. If you are adding a new code, you will be asked to verify your entry before you can continue to step 4.

Step 4: If you are adding a new code, type the description of the new code at the "Description:" prompt. If you are editing an existing code, the existing description text will appear after the "Description:" prompt, followed by the word *Replace*.

If you wish to edit the entire description, type three periods (…) after *Replace* and type the new description after the word *With* (which will appear after you type the three periods).

If you just wish to edit a portion of the description, type the portion you wish to edit after *Replace* and type the new portion of the description after the word *With* (which will appear after you have selected text to replace).

If you do not wish to edit the description at all, press the Return key at the *Replace* prompt.

Step 5: Type 0 (active) or 1 (inactive) at the "Inactive Flag:" prompt. If you want the code to be used on appropriate UB-92 forms, type 0. If you do not want the code to be used, type 1. If you type 1, the UB-92 code the Claim Editor cannot select the code.

```
      Select one of the following:

1        CONDITION CODES
2        OCCURRENCE CODES
3        OCCURRENCE SPAN CODES
4        SPECIAL PROGRAM CODES
5        VALUE CODES
BILL TYPE

Select Desired Code: 1  CONDITION CODES
      Select one of the following:

          1          EDIT
          2          ADD
          3          QUIT
Desired Action: 1// <RETURN>  EDIT

Select CONDITION CODE to Edit: 18          MAIDEN NAME RETAINED
DESCRIPTION: MAIDEN NAME RETAINED Replace...With Patient Retained Maiden Name
    Replace
       Patient Retained Maiden Name
 INACTIVE FLAG:  ACTIVE FLAG// 0    ACTIVE FLAG
```

Figure 8-58: UB-92 Code Maintenance

8.12.2 UB-92 Codes Listing (LSUB)

Main Menu → TMTP→ UCTM→ LSUB

The LSUB option enables the user to generate a list of UB-92 codes sorted by category. To print a listing of UB-92 codes, type the name of the device you wish to print the file on at the "Device:" prompt.

```
Heading: (S/C): UB-92 CODES LISTING          MAR 20, 2002   09:40     PAGE 1
CODE  DESCRIPTION
------------------------------------------------------------------
        CODE TYPE: ADMISSION SOURCE
1    PHYSICIAN REFERRAL
2    CLINIC REFERRAL
3    HMO REFERRAL
4    TRANSFER FROM A HOSPITAL
5    TRANSFER FROM SKILLED NURSING FACILITY
6    TRANSFER FROM ANOTHER FACILITY
7    EMERGENCY ROOM
8    COURT/LAW ENFORCEMENT
9    UNKNOWN
A    Transfer from a Critical Assess Hospital
B    Transfer from Another Home Health Agency

    CODE TYPE:  BILL TYPE
```

Figure 8-59: UB-92 Code Listings

8.13 Employer File Menu (EMTM)

Main Menu → TMTP→ EMTM

To eliminate data redundancy and inconsistency, the patient's and spouse's EMPLOYER fields were changed from free-text entry to be limited to entries in a New Employer file. The Employer File menu enables users to add/ edit employers, print a list of employers, print a list of all employees by employer, and merge duplicate employers in the file. These options are outlined in this section.

```
   +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
   |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
   +                   Employer File Menu                    +
   |                   ALBUQUERQUE HOSPITAL                  |
   +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
   User: CHAPEK, JADE                     12-MAR-2002  5:10 PM

   EDEM   Add/Edit an Employer
   LSEM   Employer Listing
   RPEM   List all Employees by Employer
   MREM   Merge Duplicate Employers

Select Employer File Menu Option:
```

Figure 8-60: Employer Menu

8.13.1 Add/Edit an Employer (EDEM)

Main Menu → TMTP→ EMTM→ EDEM

The Add/Edit an Employer option enables users to add new employers that are lacking in the current employer file and update employer information as needed.

The process for adding an employer and the process for editing an employer are similar enough that they will be presented together in this section. The main difference between adding and editing is that, when editing an employer, any data that has already been entered at the prompts will appear between the prompt and two slashes (//). If the user wishes to keep the existing data, he or she just needs to press the Return key after the two slashes. If the user wishes to edit the existing data, he or she must type the new data after the two slashes.

Step 1: Type the name of the employer you wish to add or edit at the "Select Employer:" prompt. If you wish to see a list of available employers, type a question mark at the prompt instead. If you are adding an employer, the system will ask you to verify your entry before you can continue to step 2.

> **Note:** Before adding a new employer, the user should ensure that it does not already exist. If, however, duplicate employers do occur, they may be merged through the Merge Duplicate Employers option (section 8.13.4).

Step 2: Type a new/edited employer name at the "Employer: [current name]//" prompt. If you do not wish to edit the employer's name, press the Return key only.

Step 3: Type the street number and name of the employers mailing address at the "Street:" prompt.

Step 4: Type the city name of the employer's mailing address at the "City:" prompt.

Step 5: Type the state abbreviation or name of the employer's mailing address at the "State:" prompt.

Step 6: Type the phone number of the employer's business office at the "Phone:" prompt.

Step 7: Type an abbreviation that you would like this employer to be found by at the "Abbreviation:" prompt. If you do not wish to give this employer an abbreviation, press the Return key at the blank prompt.

Step 8: Type the name of the company the employer uses for Workman's Comp. Claims at the "Billing Entity for Workmen's Comp:" prompt. The system may ask you to verify your selection before allowing you to continue.

```
Select EMPLOYER: TEST

Employer..: TEST// <RETURN>
Street....: 1234 ANYWHERE STREET
City......: ANYWHERE
State.....: NEW MEXICO
Zip.......: 87111
Phone.....: 505-555-4545
Abbrev....: TT

Billing Entity for Workmen's Comp.: NM BC/BS( BLUE CROSS/CROSSE MEXICO NEW SHIEL
D )
.
NEW MEXICO BC/BS INC                - 12800 NATIVE SCHOOL RD NE      Domain: NM
                                      ALBUQUERQUE, NM 87112
 OK? Y// Y
```

Figure 8-61: Add/Edit an Employer

8.13.2 Employer Listing (LSEM)

Main Menu → TMTP→ EMTM→ LSEM

The LSEM option enables the user to generate a list of employers in the Employer File. To print a listing of employers, type the name of the device you wish to print the file on at the "Device:" prompt.

```
===== EMPLOYER LISTING =====                    MAR 26,2002  10:20    PAGE 1
EMPLOYER                                  PHONE
--------------------------------------------------------------------------------

ACTIVE MILITARY

ALBUQUERQUE INDIAN HOSP                   505 248 4001
  601 VASSAR NE
  ALBUQUERQUE, NM  87106

ALBUQUERQUE MAJOR
  879 PAN AMERICA
  ALBUQUERQUE, NM

ARVISO'S CONSTRUCTION
```

Figure 8-62: Employer Listing

8.13.3 List all Employees by Employer (RPEM)

Main Menu → TMTP→ EMTM→ RPEM

The RPEM option enables the user to generate a list of employees sorted alphabetically by employer.

Step 1: Type Y at the "Do you wish the Run the Program? Y//" prompt.

Step 2: Type the name of the device you wish to print/ view the report on at the "Device:" prompt.

```
================================================================================
EMPLOYEE LISTING for All EMPLOYERS                      MAR 26,2002   Page 1
================================================================================
Employer                        Employee                          HRN
--------------------------------------------------------------------------------

ACTIVE MILITARY                 LEFTHAND,JANET K                  0

ALBUQUERQUE INDIAN HOSP         CARTER,ANITA                      64002
                                VIGIL,GLENDA                      0

ALBUQUERQUE MAJOR               CHAVEZ,GREG                       3458

ARVISO'S CONSTRUCTION           DEDIOS,JEREMY LAYNE               0
                                MANWELL,GENE S                    0
                                MUNIZ,HUBERT HARLON               0
                                MUNIZ,WILLIAM EUGENE              0
                                QUINTANA,DENNIS GEORGE            0

AT&SF RAILROAD                  REVAL,RICHARD,SR                  0
```

Figure 8-63: List All Employees by Employer

8.13.4 Merge Duplicate Employers (MREM)

Main Menu → TMTP→ EMTM→ MREM

This option enables users to merge two different but duplicate employers, or more precisely, to redirect the data pointers to a duplicate employer to point to another employer.

Step 1: Type the name or keyword for the employer you wish to merge at the "Select Employer (to Search against):" prompt. If the employer that the system finds is the employer you were looking for, type Y at the "OK?" prompt that will follow. If the employer that the system finds is not the employer that you were looking for, type N at the "OK?" prompt and repeat step 1. If the employer found is the only one the system finds to match your criteria, the system will not ask for your verification.

Step 2: Type the name or keyword for the second employer you wish to merge at the "Select (Search) for Duplicate Employer:" prompt. If the employer that the system finds is the employer you were looking for, type Y at the "OK?" prompt that may follow. If the employer that the system finds is not the insurer that you were looking for, type N at the "OK?" prompt and repeat step 2. If the employer found is the only one the system finds to match your criteria, the system will not ask for your verification.

Step 3: The system will display the insurers billing information side by side. After verifying the insurers' data, type Y or N at the "Are the two Insurers duplicates (Y/N)?"

prompt. If the employer found is the only one the system finds to match your criteria, the system will not ask for your verification.

If you type N, the system will ask if you wish to continue dup checking the first employer. If you type Y to this prompt, repeat steps 2-3. If you type N to this prompt, repeat steps 1-3.

Step 4: The system will ask you to select the most accurate of the duplicate employers. Type 1 or 2 (the numbers corresponding to the two employers you are merging) at the "Which of the two is most accurate:" prompt.

Step 5: The system will merge the least accurate employer file with the more accurate employer file and then ask you if you wish to continue running the program. If you wish to continue merging employers, type Y. If you are finished merging employers, type N and you will be returned to the Employer File menu.

```
Select EMPLOYER (to Search against): TEST

Dup-Check for: TEST
               1234 ANYWHERE ST.
               ANYWHERE, NM 87111
================================================
Select (SEARCH) for Duplicate EMPLOYER: DEMO
_____________________________________________________________________________
[1]  TEST                              | [2]  DEMO
     1234 ANYWHERE ST.                 |      1234 ANYPLACE
     ANYWHERE, NM 87111                |      ANYWHERE, NM 87111
-----------------------------------------------------------------------------

     Are the two Employers duplicates (Y/N)? YES


     Select one of the following:

          1         TEST
          2         DEMO

     Which of the two is most accurate: 1  TEST
OK, MERGING..

Re-directing Pointers...


Do you wish to continue running this program? Y// Y
```

Figure 8-64: Merging Duplicate Insurers

8.14 Drug File Menu (DRTM)

Main Menu → TMTP→ DRTM

Drug file maintenance is done by the pharmacy, but two drug file inquiry type options have been included in this menu for user convenience. The Drug File menu enables users to print a listing of drugs and display a drug file entry. These options are outlined in this section.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
          +                     Drug File Menu                      +
          |                   ALBUQUERQUE HOSPITAL                  |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                       26-MAR-2002 10:26 AM


   LSDR   Drug Listing
   IQDR   Display a Drug File Entry

Select Drug File Menu Option:
```

Figure 8-65: Drug File Menu

8.14.1 Drug Listing (LSDR)

Main Menu → TMTP→ DRTM→ LSDR

The LSDR option enables the user to generate a list of the drugs in the Drug file, sorted alphabetically and showing the NDC Number and DISPENSE FEE for each drug.

Step 1: Type Y or N at the "Do you wish to run the program:" Prompt. If you wish to generate a list of drugs in the Drug file, type Y. If you have selected this option on accident, type N and you will be returned to the Drug File menu.

Step 2: Type Y or N at the "Should the Listing display the Drug Synonyms?" prompt. If you want the Drug synonyms also included on the list, type Y. If you do not want the drug synonyms on the list, type N. **Step 3**: Type the name of the device that you wish to view/print the listing on at the "Device:" prompt.

```
This program generates a listing of the Drug File, sorted in alphabetic order,
showing the NDC Number and Dispense Fee of each drug.

Do you wish the Run the Program? Y// YES

Should the Listing display the Drug Synonyms? N// YES



Output DEVICE: HOME
```

Figure 8-66: Generating a Drug File Listing

An example of the Drug File Listing has been included in Figure 8-67.

```
================================================================================
DRUG FILE LISTING                                        MAR 26,2002   Page 1
================================================================================
                                                                 Dispense Fee
     Drug / Synonym                              NDC Number       Per Unit    Units
--------------------------------------------------------------------------------
ACETAMINOPHEN 120MG SUPP.                      182-1662-11         0.139      SUP
      Acet120
ACETAMINOPHEN 160MG/5ML 120ML                  536-0122-97         0.032      BT
      Acet160
ACETAMINOPHEN 325MG SUPP                                           0.008      10
      Acet325
ACETAMINOPHEN 325MG TAB                        10135-0123-62       0.007      TAB
      Acet325
ACETAMINOPHEN 325MG TAB U/D                                        0.000
ACETAMINOPHEN 650MG SUPP                       245-0122-12         0.000      SUP
      Acet650
ACETAMINOPHEN 80MG CHEWABLE                    536-3233-07         0.000      TAB
      Acet80
ACETAMINOPHEN 80MG/0.8ML 15ML                  45-0187-03          0.000      BT
      Acet80D
```

Figure 8-67: Drug File Listing Sample

8.14.2 Display a Drug File Entry (IQDR)

Main Menu → TMTP→ DRTM→ IQDR

The IQDR option enables users to view all information on file for a specific drug. To view the file information on a drug, type the name or drug number of the drug you are looking for at the "Select Drug:" prompt. The data will appear on your screen. Only those fields that contain data will appear on the screen.

```
                          *** DRUG FILE INQUIRY ***

================================================================================
NUMBER: 5297                              GENERIC NAME: ORTHO-NOVUM 1/35-28
  STANDARD SIG: T1T DY UD FBC             LOCAL NON-FORMULARY: N/F
  APPLICATION PACKAGES' USE: IOU          REORDER LEVEL: 9999
  CURRENT INVENTORY: 10000                DIVISION: DULCE HEALTH CENTER
  INACTIVE DATE: AUG 30, 1989
================================================================================

Select DRUG:
```

Figure 8-68: Display a Drug File Entry

8.15 Visit Type Maintenance (VITM)

Main Menu → TMTP→ VITM

The Visit Type Maintenance option enables users to establish new visit types or edit existing visit types. For example, creating a new visit type would be necessary if the local Medicaid Intermediary specified a special program to be billed differently from the existing visit types (Outpatient, Inpatient and Dental). After creating the new visit type, a link from the Insurer file (section 8.6) could be established for controlling the mode of billing. Each claim to be billed in this manner would require manual linking to this visit type.

The process for adding a visit type and the process for editing a visit type are similar enough that they will be presented together in this section. The main difference between adding and editing is that, when editing a visit type, any data that has already been entered at the prompts will appear between the prompt and two slashes (//). If the user wishes to keep the existing data, he or she just needs to press the Return key after the two slashes. If the user wishes to edit the existing data, he or she must type the new data after the two slashes.

Step 1: Type the name of the visit type you wish to add or edit at the "Select Visit Type:" prompt. If you are adding a new visit type, you will be asked to verify your addition before you can continue to step 2.

Step 2: Type the number you wish to assign to the visit type at the "3P Visit Type Number:" prompt. If you are editing a visit type, the number currently assigned to the visit type will appear between the prompt and two slashes (//). If you are adding a visit type, the next available visit type number will appear between the prompt and two slashes (//). If you wish to accept the default number, press the Return key without typing anything at this prompt. **Note**: The visit type number must be unique but is user-specific and has no intrinsic meaning to the billing system.

Step 3: Type a new visit type name (if desired) at the "Name:" prompt. If you wish to leave the visit type name as it is, press the Return key without typing anything at this prompt.

Step 4: Type 111 (inpatient), 131 (outpatient), or 711 (rural clinic) at the "UB-92 Bill Type:" prompt. If the visit is an inpatient visit, type 111. If the visit is an outpatient visit, type 131. If the visit is at a rural clinic, type 711.

> **Note**: The UB-92 Bill Type field determines how the system will process the claim. If the visit type is for an inpatient visit, it must be specified as such so that the Claim Editor will allow access to inpatient data fields.

Step 5: Type the clinic type number that applies to the visit type at the "Select Clinic:" prompt.

> **Note**: When the Clinic field is specified for a visit type, all automatically created claims from a visit at the same clinic will contain this visit type, as defined for the primary insurer.

If you are adding a new clinic type, the system will ask you to verify your entry. The "Select Clinic:" prompt will continue to reappear, allowing you to enter multiple clinic types for the visit type, until you press the Return key at a blank "Select Clinic:" prompt. When you are finished adding clinic types, you will be returned to the Table Maintenance menu.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
          +                 Visit Type Maintenance                  +
          |                  ALBUQUERQUE HOSPITAL                   |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                        26-MAR-2002 10:33 AM

Select VISIT TYPE: DEMO 2
  Are you adding 'DEMO 2' as a new 3P VISIT TYPE (the 35TH)? No// Y  (Yes)
   3P VISIT TYPE NUMBER: 903// <RETURN>
NAME: DEMO 2// <RETURN>
UB-92 BILL TYPE: 131  OUTPATIENT
Select CLINIC: 92  DIALYSIS        92
  Are you adding 'DIALYSIS' as a new CLINIC (the 1ST for this 3P VISIT TYPE)? No
// Y  (Yes)

Select CLINIC:
```

Figure 8-69: Visit Type Maintenance

8.16 Charge Master Add/Edit (CMTM)

Main Menu → TMTP→ CMTM

The Charge Master Add/ Edit option enables users to add a new or modify a current entry in the Third Party Charge Master file. The Charge Master file is used to bill for supplies. Users cannot enter products on page 8J of the Claim Editor unless it already exists in this file.

The process for adding a Charge Master file entry and the process for editing a Charge Master file entry are similar enough that they will be presented together in this section. The main difference between adding and editing is that, when editing a Charge Master file entry, any data that has already been entered at the prompts will appear between the prompt and two slashes (//). If the user wishes to keep the existing data, he or she just needs to press the Return key after the two slashes. If the user wishes to edit the existing data, he or she must type the new data after the two slashes.

Step 1: Type the name of the supply that you wish to add or edit at the "Select 3P Charge Master Item Description:" prompt. If you are adding a new entry, the system will ask you to verify your entry before you can continue to step 2.

Step 2: If you wish to change the description/ name of the item in the Charge Master file, type the new description/ name at the "Item Description:" prompt. If you do not wish to change the description/ name, press the Return key at the blank "Item Description:" prompt.

Step 3: Type the revenue code number that should be used to bill for this item at the "Revenue Code:" prompt. If you need to see a list of options, type two question marks (??) at the prompt first.

Step 4: Type the HCPCS code that you wish to associate with the item at the "HCPCS code:" prompt. If you need to see a list of options, type two question marks (??) at the prompt first.

Step 5: Type the item's UPC code at the "UPC:" prompt. The UPC code cannot be more than 10 characters.

> **Note:** This option supports bar coding. If you have a scanner, you may scan in the UPC code at this prompt.

Step 6: Type any additional identifiers for the item at the "Other Identifier:" prompt.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
          +                 Charge Master Add/Edit                  +
          |                  ALBUQUERQUE HOSPITAL                   |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                      26-MAR-2002 10:36 AM

Select 3P CHARGE MASTER ITEM DESCRIPTION: TEST ENTRY
ITEM DESCRIPTION: TEST ENTRY// <RETURN>
REVENUE CODE: 450// <RETURN>
HCPCS CODE: 11301// <RETURN>
UPC: 1234567890// <RETURN>
OTHER IDENTIFIER: 0987654321
```

Figure 8-70: Charge Master Add/Edit

8.17 Dental Remap Table Maintenance (DMTM)

Main Menu → TMTP→ DMTM

This option enables the user to remap IHS dental codes to dental codes accepted by an insurer, which is essential for receiving payment from the insurers.

In the example below, the user needs to remap the dental codes for 8160 because most of his facility's insurers don't accept this code and will reject these claims. The user knows that the insurers will accept code 8110, however, and he has remapped the IHS dental code 8160 to the standard code 8110.

Step 1: Type the name of the insurer or name of the table you wish to remap the dental codes for at the "Select 3P Dental Recode Table Name (Insurer):" prompt.

Step 2: Type 0, S, D at the "Code Prefix:" prompt if the insurer requires a dental code prefix for dental claims.

Step 3: Type the code number that you wish to remap at the "Select IHS Code:" prompt.

Step 4: Press the Return key at the "IHS Code:" prompt to confirm your selection.

Step 5: Type the code number that you wish to remap the table to at the "Remap to Code:" prompt.

Step 6: The "Select IHS Code:" prompt will reappear. If you wish to continue remapping dental codes for the selected insurer/ table, type the next code number at this prompt and repeat steps 2-5. If you are finished remapping dental codes for this insurer/table, press the Return key at a blank "Select IHS Code:" prompt and you will be returned to the Table Maintenance menu.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
          +             Dental Remap Table Maintenance              +
          |                  ALBUQUERQUE HOSPITAL                   |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                        26-MAR-2002 4:14 PM

Select 3P DENTAL RECODE TABLE NAME (INSURER): TEST( TEST )
.
LINDA TEST INS                          - 123 MAIN
                                          ANYWHERE, NM 12345
 OK? Y// Y

CODE PREFIX: D  D
Select IHS CODE: 8160
  IHS CODE: 8160// <RETURN>
  REMAP TO CODE: 8110
Select IHS CODE: <RETURN>
```

Figure 8-71: Dental Remap Table Maintenance

8.18 Form Locator Override (FLTM)

Main Menu → TMTP→ FLTM

The FLTM option enables users to customize insurer and visit type information on the HCFA-1500 forms. This information is site, insurer, and form specific.

Step 1: Type the name of the insurer that you wish to edit information for at the "Select 3P Insurer:" prompt. The system will ask you to verify your selection before you can continue to step 2.

Step 2: Type the name or number of the form that you wish to edit information for at the "Select 3P Export Mode Format:" prompt.

Step 3: Type the number that corresponds to the box on the selected form that you wish to override and add data to at the "Select Form Locator:" prompt. The system will automatically present a list of options before the prompt.

Step 4: Type the number or name of the visit type you wish to restrict this change to at the "Enter visit type, or leave blank for all:" prompt. If you wish to make this override change on all claims for the specified insurer on the specified form, regardless of visit type, leave this prompt blank by just pressing the Return key at the blank prompt. The system will ask

you to verify your selection (if you selected a specific visit type). The system will allow multiple visit types to be selected at this prompt.

Step 5: Type 1 (Add/Edit) or 2 (Delete) at the "Add or Delete Entry?" prompt. If you wish to remove the current entry in the specified form field, type 2. If you wish to add a new value to the specified form field or edit the data in the specified form field, type 1.

If you type 2, the system will deleted the value in the specified form field and return you to the Table Maintenance menu.

If you type 1, the system will prompt you for the new value for the specified form field. Type the value you wish to have print on the form at the "Data Value:" prompt. The system will add the data value to the form and return you to the Table Maintenance menu.

```
Select 3P INSURER: TEST( TEST )
.LINDA TEST INS                          - 123 MAIN
                                          ANYWHERE, NM 12345
 OK? Y// Y

Select 3P EXPORT MODE FORMAT: 14    HCFA-1500 Y2K        HCFA 1500 Y2K version

     Select one of the following:
          10        RESERVED FOR LOCAL USE
          11        BOX 11C - INSURANCE PLAN/PROGRAM NAME
          19        RESERVED FOR LOCAL USE
          24        LINE ITEMS
          32        WHERE SERVICES RENDERED
          33        BILLING INFO

Select Form Locator: 19  RESERVED FOR LOCAL USE
Enter visit type, or leave blank for all. 550  TEST

Current Value: TEST DATA VALUE
Visit Type: 550

     Select one of the following:
          1         ADD/EDIT
          2         DELETE

Add or Delete Entry?: ADD/EDIT// 1  ADD/EDIT
DATA VALUE: TEST DATA VALUE
```

Figure 8-72: Form Locator Override

8.19 Initialize New Facility (SSTM)

Main Menu → TMTP→ SSTM

This option enables users to initialize a facility new to the ABM package. User may only initialize the facility to which they are logged in. The computer will initialize the necessary files and notify the user of the files initialized when the site initialization is complete.

To initialize a new facility, type Y at the "Initialize Site [current site name]:" prompt. If you have selected this option by mistake, type N and you will be returned to the Table Maintenance menu.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |         THIRD PARTY BILLING SYSTEM - VER 2.5                        |
        +                Initialize New Facility                              +
        |                       SELLS HOSP                                    |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: MAROFSKY,SANDRA                   19-MAR-2002 9:05 AM

This option will initialize a new location for the Third Party
Billing Package. You are logged in as  SELLS HOSP  TUCSON     SELLS  01

Initialize Site SELLS HOSP? NO// YES

Initializing 3P Claim Data file
Initializing 3P Bill file
Initializing 3P Parameter file
Initializing 3P TX Status file
Initializing 3P Area Office Export file

Site Initialized.
```

Figure 8-73: Initialize New Facility

9 Eligibility Menu (ELTP)

Main Menu → ELTP

This menu enables the user to access a selection of eligibility options in the Patient Registration package (AG). Through this menu, a user can edit a specific patient registration page, maintain the private insurance policy file, and view eligibility reports.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
          +                   Eligibility Menu                      +
          |                 ALBUQUERQUE HOSPITAL                    |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                      26-MAR-2002 10:48 AM


   EDEL   Edit a PATIENT REGISTRATION Third Party Page ...
   POEL   Private Insurance Policy Maintenance Menu ...
   RPEL   Eligibility Reports Menu ...

Select Eligibility Menu Option:
```

Figure 9-1: Eligibility Menu

9.1 Edit a Patient Registration Third Party Page (EDEL)

Main Menu → ELTP→ EDEL

This option enables the user to edit a patient's Medicare, Medicaid, Railroad and Private Insurance eligibility in Patient Registration through the Third Party system. From this menu, the user must select a page to edit. A user may select page 4, 5, or 6 of the patient's Medicare eligibility information or the patient's private insurance eligibility information. Each of these options is outlined in this section.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
          +      Edit a PATIENT REGISTRATION Third Party Page       +
          |                 ALBUQUERQUE HOSPITAL                    |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                      26-MAR-2002 10:48 AM


   MRED   Medicare Eligibility Edit (Page 4)
   MDED   Medicaid  Eligibility Edit (Page 5)
   RRED   RailRoad Retirement Edit (Page 6)
   PIED   Private Insurance Eligibility Edit (Page 7)

Select Edit a PATIENT REGISTRATION Third Party Page Option:
```

Figure 9-2: Patient Registration Third Party Page Menu

9.1.1 Medicare Eligibility (Page 4) (MRED)

Main Menu → ELTP→ EDEL→ MRED

This option provides users with direct access to the Medicare Eligibility Page of the Patient Registration system. Medicare insurance is only primary over a private insurer **IF** the patient has an employment status of "retired" in patient registration. Refer to the Patient Registration package's user manual for additional information on using this option.

9.1.2 Medicaid Eligibility (Page 5) (MDED)

Main Menu → ELTP→ EDEL→ MDED

This option provides users with direct access to the Medicaid Eligibility Page of the Patient Registration system. Refer to the Patient Registration package's user manual for additional information on using this option.

9.1.3 Railroad Retirement Edit (Page 6) (RRED)

Main Menu → ELTP→ EDEL→ RRED

This option provides users with direct access to the Railroad Eligibility Page of the Patient Registration system. Refer to the Patient Registration package's user manual for additional information on using this option.

9.1.4 Private Insurance Eligibility Edit (Page 7) (PIED)

Main Menu → ELTP→ EDEL→ PIED

This option provides users with direct access to the Private Insurance Eligibility Page of the Patient Registration system. Refer to the Patient Registration package's user manual for additional information on using this option.

9.2 Private Insurance Maintenance Menu (POEL)

Main Menu → ELTP→ POEL

This menu enables users to maintain private insurance policies in the Patient Registration package through the ABM system. Through this menu, users can add or edit a private insurance policy, generate a list of all policies and members by insurer, and merge duplicate insurance policies.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
          +       Private Insurance Policy Maintenance Menu         +
          |                   ALBUQUERQUE HOSPITAL                  |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                      26-MAR-2002 10:50 AM

   EDPO   Add/Edit a Private Insurance Policy
   LSPO   Listing of Policies and Members by Insurer
   MRPO   Merge Duplicate Insurance Policies

Select Private Insurance Policy Maintenance Menu Option:
```

Figure 9-3: Private Insurance Policy Maintenance Menu

9.2.1 Add/Edit a Private Insurance Policy (EDPO)

Main Menu → ELTP→ POEL→ EDPO

This option enables users to establish a private insurance policy and specify its members in the Patient Registration program through the ABM system. Refer to the Patient Registration package's user manual for additional information on using this option.

9.2.2 Listing of Policies and Members by Insurer (LSPO)

Main Menu → ELTP→ POEL→ LSPO

This option enables users to obtain a listing of the private insurance policies, displaying the associated members of each policy, sorted by the insurer from the Patient Registration program through the ABM system. Refer to the Patient Registration package's user manual for additional information on using this option.

9.2.3 Merge Duplicate Insurance Policies (MRPO)

Main Menu → ELTP→ POEL→ MRPO

The option enables users to merge two insurance policies together. When used, this option will transfer patients from one policy to another. Refer to the Patient Registration package's user manual for additional information on using this option.

9.3 Eligibility Reports Menu (RPEL)

Main Menu → ELTP→ RPEL

This menu enables users to access the eligibility reports in the Patient Registration program through the ABM system. Through this menu, users can generate lists of Medicare enrollees

(Part A and/or Part B), Medicaid enrollees, patients with private insurance eligibility, patients with VA eligibility, commissioned officers and dependents, and PCC visits by commissioned officers and dependents. These options are outlined in this section.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
           +               Eligibility Reports Menu                  +
           |                 ALBUQUERQUE HOSPITAL                    |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: CHAPEK,JADE                        26-MAR-2002 10:51 AM

   MARP   Listing of Medicare Part A Enrollees
   MBRP   Listing of Medicare Part B Enrollees
   MDRP   Listing of Medicaid Enrollees
   PIRP   Private Insurance Eligibility Listing
   VARP   VA Eligibility Listing
   CORP   Listing of Commissioned Officers and Dependents
   VCRP   Visits by Commissioned Officers and Dependents

Select Eligibility Reports Menu Option:
```

Figure 9-4: Eligibility Reports Menu

9.3.1 Listing of Medicare Part A Enrollees (MARP)

Main Menu → ELTP→ RPEL→ MARP

This option will print an alphabetic list of patients registered at a selected facility and actively enrolled in Medicare Part A. Refer to the Patient Registration package's user manual for additional information on using this option.

9.3.2 Listing of Medicare Part B Enrollees (MBRP)

Main Menu → ELTP→ RPEL→ MBRP

This option will print an alphabetic list of patients registered at a selected facility and actively enrolled in Medicare Part B. Refer to the Patient Registration package's user manual for additional information on using this option.

9.3.3 Listing of Medicaid Enrollees (MDRP)

Main Menu → ELTP→ RPEL→ MDRP

This option will print an alphabetic list of patients registered at a selected facility and actively enrolled in Medicaid. Refer to the Patient Registration package's user manual for additional information on using this option.

9.3.4 Private Insurance Eligibility Listing (PIRP)

Main Menu → ELTP→ RPEL→ PIRP

This option will print an alphabetic list of patients registered at a selected facility and actively enrolled in private insurance. Refer to the Patient Registration package's user manual for additional information on using this option.

9.3.5 VA Eligibility Listing (VARP)

Main Menu → ELTP→ RPEL→ VARP

This option will print an alphabetic list of all patients who are veterans. Refer to the Patient Registration package's user manual for additional information on using this option.

9.3.6 Listing of Commissioned Officers and Dependents (CORP)

Main Menu → ELTP→ RPEL→ CORP

This option will print an alphabetic list of all patients who are Commissioned Officers or dependents thereof. Refer to the Patient Registration package's user manual for additional information on using this option.

9.3.7 Visits by Commissioned Officers and Dependents (VCRP)

Main Menu → ELTP→ RPEL→ VCRP

This option will print a listing of commissioned officers and dependents thereof that have had visits after a specified date. Refer to the Patient Registration package's user manual for additional information on using this option.

10 Payment Posting (PPTP)

Main Menu → PPTP

This menu enables users to post payments in the ABM system. However, if the user's site is also using the RPMS A/R package (BAR), payment posting should occur in that package.

Step 1: Type Y or N at the "Screen-out the Selection of Bills that are Completed?" prompt. If you want bills that are in a Completed status (unobligated balance is equal to zero) to be unselectable, type Y.

Step 2: Type the name or number of the patient or bill at the "Select Bill or Patient:" prompt. If the text you enter at this prompt matches more than one file in the system, you will be prompted to select from a list of matches before you can continue to step 3.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
          +                   Payment Posting                       +
          |                 ALBUQUERQUE HOSPITAL                    |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                      26-MAR-2002 10:55 AM

Screen-out the Selection of Bills that are Completed?  Y// ES

Select BILL or PATIENT: 128C
```

Figure 10-1: Payment Posting Step 1-2

Step 3: The bill summary will appear on your screen. Type A (add), D (Delete), E (Edit), V (View), or Q (Quit) at the "Desired Action:" prompt to select your action. In the example in Figure 10-2, the user chose to Add.

> **Note:** Not all of these options will be available for all billing statuses. To see a list of available options, refer to the data in parentheses after the "Desired Action:" prompt.

If you chose to add a payment, continue to step 4. If you chose to delete a payment, skip to step 5. If you chose to edit a payment, skip to step 6. If you chose to view a payment, the bill display will appear on your screen. If you chose to quit the payment posting option, you will be returned to the main Third Party Billing menu.

```
~~~~~~~~~~~~~~~~~~~~~~~~~PAYMENT POSTING ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient:  KERR, SARAH [HRN:2802]          F     04-01-1997  772873490
. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
Visit:      06-01-90    SELLS HOSP              INPATIENT          GENERAL
 Bill:      1A          BC/BS OF MARYLAND INC   COMPLETED        $2,662.64
. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
            Amount      Payment           Deduct      Write Off-
            Billed        Date    Payment Co-Ins      Adjustment  Balance
            =======     =======   ======= =======     ==========  ========
  [1]       2,662.64    06-15-92   200.00  100.00       00.00     2,362.64

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -
NOTE:  A Sister Bill (1B) exists with a balance of $496.00
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -
Desired ACTION (Add/Del/Edit/View/Quit):  A//  <RETURN>
```

Figure 10-2: Payment Posting Step 3

Step 4: Adding a Payment

Action 1: Type the date of the payment at the "Enter New Payment Date:" prompt.

Action 2: Type the amount of the payment at the "Payment Amount:" prompt.

Action 3: Type the amount of the deductible at the "Deductible Amount:" prompt. If the patient does not have a deductible, leave this field blank and press the Return key. The system will display the updated unobligated balance on your screen.

> **Note**: Any deductible or co-insurance amount specified by the billed party should be entered in the DEDUCTIBLE or CO-INSURANCE AMOUNT fields, accordingly. Late payments can be posted at any time and existing payments can always be edited.

Action 4: Type the amount the write-off (per your facilities agreement with the insurer, up to the unobligated balance amount) at the "Write-off Amount:" prompt. The system will check for a secondary insurer to bill and display them on the screen. Answer any additional prompts related to the additional insurers/ unbilled resources as they appear on your screen.

> **Note**: As shown in this example (Figure 10-3), after all anticipated collections for a bill have been received, the remainder of the bill may be written off so that secondary sources can be billed. The amount entered as the write-off can be applied to the next billing entity or discarded as uncollectable.

```
Enter NEW PAYMENT Date:  T-1
Payment Amount . . . . . . . . . .:  2000
Deductible Amount . . . . . . . . :  300

                        (Unobligated Balance:  62.64)

Write-off Amount (0-62.64:    62.64

Checking for Secondary Billing . . .
- - - - - - - - - - - - - - - - - - - - - - - - - - -

Unbilled Sources:  [1]  NON-BENEFICIARY PATIENT

Do you wish to apply the Write Off to the next Bill (Y/N)?  Y//  <RETURN>  ES

A Sister Bill (1B) exists with an unobligated balance, it must be resolved
before proceeding to bill a secondary entity.
```

Figure 10-3: Adding a Payment Step 4

As mentioned in this example (Figure 10-3), the sister bill must be resolved before any unbilled secondary sources may be billed.

```
Unobligated Balance:  0.00)

Checking for Secondary Billing …
Unbilled Sources:  [1]  NON-BENEFICIARY PATIENT

Claim Number:  1 is now Open for Editing!

Enter CLAIM EDITOR for APPROVAL of Secondary Entity (Y/N)? Y// <RETURN>
```

Figure 10-4: *Payment Posting Step 4: Adding a Payment, Secondary Billing*

Once the bill is resolved (unobligated balance equals zero) and unbilled sources exist, the Claim Editor can be reopened ad hoc to bill a secondary entity. If the unpaid balance is zero (no deductible or write-offs were entered), the user is prompted to cancel the original claim.

Step 5: Deleting a Payment

Type Y or N at the "Do you wish PAYMENT Number 1 DELETED?" prompt. If more than one payment exists, then the system will first ask you wish payment you wish to delete. If you have selected this option by mistake, type N.

Deleting a payment completely removes it from the record. If you only need to make a change to the payment, use the edit option instead.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAYMENT POSTING ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JANICE [no HRN]                          F   01-01-1933 234441170
................................................................................
Visit: 05-22-1996ALBUQUERQUE HOSPITAL             OUTPATIENT             DENTAL
 Bill: 43548B    CHICAGO HLTH CENTER ILGW UNION   PARTIAL PAYMENT       $671.00
--------------------------------------------------------------------------------

       Amount    Payment                 Deduct    Write Off-
       Billed      Date     Payment      Co-Ins    Adjustment   Balance
     ==========  ========  ==========  ==========  ==========  ==========
[1]      671.00  03-26-2002      0.00        0.00        0.00      671.00

--------------------------------------------------------------------------------
NOTE: A Sister Bill (43548A) exists with a balance of $10.00
--------------------------------------------------------------------------------
Desired ACTION (Add/Del/Edit/View/Quit): D


Do you wish PAYMENT Number 1 DELETED? Y
```

Figure 10-5: *Payment Posting Step 5: Deleting a Payment*

11 Electronic Media Claims (EMTP)

Main Menu → EMTP

The Electronic Media Claims Menu enables users to create files containing claims for electronic submission to insurers. From this menu, users can view a batch summary, create an EMC file, recreate an EMC file, and view a summary of bills ready to be submitted electronically. These options are outlined in this section.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5                          |
          +                Electronic Media Claims                                 +
          |                  ALBUQUERQUE HOSPITAL                                  |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                      26-MAR-2002 11:03 AM


   BSEM   Batch Summary
   CREM   Create EMC File
   RCEM   Re-Create an EMC File
   SUEM   Summary of Bills Ready for Submission

Select Electronic Media Claims Option:
```

Figure 11-1: Electronic Media Claims Menu

If the facility wants to transmit claims electronically, the user must perform the following steps **prior** to APPROVING claims:

- Change the mode of export for the visit type desired to an electronic format (UB-92-E).
- Enter the five-digit receiver identification number in the AO CONTROL NUMBER field. For Medicare claims via Blue Cross Blue Shield of Texas, this number will be 00401. For Private insurance companies, it will be the unique five-digit number assigned by the National Association of Insurance Commissioners (NAIC).

11.1 Batch Summary (BSEM)

Main Menu → EMTP→ BSEM

This option enables users to review the billing information for batches that have already been created.

Step 1: Type the export batch number you wish to start your summary with at the "Select beginning export batch:" prompt. If you need to see a list of export batches available for review, type two question marks (??) at this prompt.

Step 2: Type the export batch number you wish to end your summary with at the "Select ending export batch:" prompt. If you need to see a list of export batches available for

review, type two question marks (??) at this prompt. If you only want to see the summary for a single batch, type the same batch number at this prompt that you typed in step 1.

Step 3: Type the name of the device you wish to view/ print the summary report on at the "Device:" prompt.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5                          |
          +                     Batch Summary                                      +
          |                   ALBUQUERQUE HOSPITAL                                 |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                      26-MAR-2002 11:05 AM

Select beginning export batch: 256  12-19-2001@14:30:39     UB-92-E V5  MEDICARE
                                      MEDICARE                HANNA,SHONDA

Select ending export batch: 258  12-19-2001@15:42:03     HCFA-1500-E  MEDICAID
ARIZONA MEDICAID                                              HANNA,SHONDA
Enter DEVICE: HOME//
```

Figure 11-2: Creating an EMC Batch Summary

```
                                BATCH SUMMARY                                Page: 1
BATCH DATE: DEC 19, 2001@14:30:39
INSURER: MEDICARE
FORMAT: Electronic UB-92 (NSF Version 5)
EMC FILE NAME: E0040004.353
================================================================================
BILL #       HRN     PATIENT                    SERVICE DATE FROM       AMOUNT
--------------------------------------------------------------------------------


SITE: ALBUQUERQ HO                        BILL TYPE: 831

   44129A    44362   JACKSON,DONALD M              MAR 03, 1999         596.00

BATCH TOTAL:                                                            596.00
```

Figure 11-3: Batch Summary Report Sample

11.2 Create EMC File (CREM)

Main Menu → EMTP→ CREM

This option enables the user to create an EMC file containing bills that have been approved but were not included in an EMC batch.

> **NOTE:** If the host file was selected as the EMC file preference, the facility is responsible for transmitting the file from the facility to the appropriate third party.

Step 1: The computer displays a list of insurers with an electronic mode of export from which the user may choose. The user is also shown the bill type, number of bills and total bill amount for that line item. Type the sequence number that corresponds to the insurer you wish to create the EMC file for at the "What sequence number:" prompt.

Step 2: Type Y or N at the "Proceed?" prompt. If you wish to continue creating the EMC batch, type Y. The system will create an entry in the 3P TX Status file and display the location and visit type for which the file is being created.

Step 3: Type the name of the path where the file will be stored. The default value is the value in the Table Maintenance Site Parameters, but you may enter any valid path name. If you want to accept the default value, press the Return key without typing anything at the prompt.

Step 4: Type a name for the file at the "Enter File Name:" prompt. The default value in Figure 11-4 is E5538701.265 where E = electronic, 55387 = AO Control number, 01 = 1st transmission, and .265 = Julian date transmitted. You may use any value system that is unique and meaningful to your facility. The value may not contain more than 8 characters followed by a decimal followed by 3 characters.

After you have typed a file name, the system creates the file. The file type should have already been specified in Site Parameters under Table Maintenance.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5                          |
          +                    Create EMC File                                     +
          |                  ALBUQUERQUE HOSPITAL                                  |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                      26-MAR-2002 11:06 AM

SEQ   INSURER                     BILL TYPE  EXPORT MODE  # OF BILLS    BILL AMT
-------------------------------------------------------------------------------

  1   MEDICARE                        831   UB-92-E V4         1       6,143.00
  2   SAFEGUARD HEALTH PLANS INC      111   UB-92-E V4         1       3,040.00

What sequence number (1 - 2):  1
Proceed? YES// YES
ENTRY CREATED IN 3P TX STATUS FILE.
LOCATION: ALBUQUERQ HO@1546
VISIT TYPE: AMBULATORY SURGERY
??
Enter Path: /usr/spool/uucppublic/  Replace <RETURN>
Enter File Name: : E0040001.85// <RETURN>
BATCH #1460264

Writing bills to file.

Finished.

Enter RETURN to continue or '^' to exit:
```

Figure 11-4: Create EMC File

11.3 Recreate an EMC File (RCEM)

Main Menu → EMTP→ RCEM

This option enables users to re-create an EMC file if necessary. This function is particularly useful when an original EMC file is lost.

Step 1: Type the original date of export at the "Select 3P TX Status Export Date:" prompt. The system will ask you to confirm your selection before you can continue to step 2.

Step 2: Type the path name for the new file at the "Enter Path:" prompt. Press the Return key alone to accept the default path.

Step 3: Type the file name for the new file at the "Enter File Name:" prompt. Press the Return key alone to accept the default path. The new (duplicate) file is created.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5                          |
          +                Re-Create an EMC File                                   +
          |                 ALBUQUERQUE HOSPITAL                                   |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                      26-MAR-2002 11:18 AM

Select 3P TX STATUS EXPORT DATE: T   MAR 26, 2002
  partial match to:  MAR 26, 2002@11:07:42       UB-92-E V4  MEDICARE  MEDICARE
                                                                CHAPEK,JADE
         ...OK? Yes// Y  (Yes)
Enter Path: /usr/spool/uucppublic/  Replace <RETURN>
Enter File Name: : E0040002.85// <RETURN>
BATCH #1460264

Writing bills to file.

Finished.

Enter RETURN to continue or '^' to exit:
```

Figure 11-5: Re-Create an EMC File

11.4 Summary of Bills Ready for Submission (SUEM)

Main Menu → EMTP→ SUEM

This option enables users to display a summary or detail report of bills that are already approved but that are not included in an EMC batch.

The summary information of possible batches will appear on the screen and you will be prompted to see more details. Type Y or N at the "Show detail?" prompt.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5             |
          +         Summary of Bills Ready for Submission             +
          |                  ALBUQUERQUE HOSPITAL                     |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                      26-MAR-2002 11:20 AM

SEQ   INSURER                    BILL TYPE  EXPORT MODE  # OF BILLS    BILL AMT
--------------------------------------------------------------------------------

  1   MEDICARE                        831   UB-92-E V4         1       6,143.00
  2   SAFEGUARD HEALTH PLANS INC      111   UB-92-E V4         1       3,040.00

Show detail ? NO// YES

What sequence number (1 - 2):  1
```
Figure 11-6: Summary of Bills Ready for Submission

If you type Y, the following information is displayed on your screen.

```
                     BILLS READY FOR SUBMISSION                 Page: 1
          FORMAT: UB-92 Electronic (NSF Version 4)

================================================================================
BILL #       HRN     PATIENT                     SERVICE DATE FROM       AMOUNT
--------------------------------------------------------------------------------

ALBUQUERQ HO                             VISIT TYPE: AMBULATORY SURGERY

   137A      773322  DANIELSON,THOMAS               AUG 23, 1990       6,143.00
                                                                     ----------
                                                                       6,143.00

                    TOTAL                                              6,143.00
```
Figure 11-7: Detail listing of Bills Ready for Submission

12 Set Site (SSTP)

Main Menu → SSTP

This menu option will allow the user to choose the site to which he is to be logged in.

Type the name of the facility that you wish to be logged into instead of your current site at the “Enter your facility’s name:” prompt. You may only select from those facilities assigned to you through the “Select DIVISION” multiple in the New Person file.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
          +                         Set Site                        +
          |                  ALBUQUERQUE HOSPITAL                   |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: CHAPEK,JADE                      26-MAR-2002 11:22 AM

Enter your facility's name: ALBUQUERQUE HOSPITAL//
```

Figure 12-1: Set Site

The user may only select from those facilities assigned to them via the “Select DIVISION” multiple in the New Person file.

13 Glossary

Accident/TORT Related Insurance	Insurance covering accidents resulting from a third party's action. Party's action may involve a civil court process in an attempt to require payment by the Third party, other than no fault liability. Also includes no fault automobile insurance.
Ambulatory Care	All types of health services that are provided on an outpatient basis, in contrast to services provided in the home or to persons who are hospital inpatients.
Ambulatory Surgery	Surgery performed as an outpatient visit at a HCFA approved facility.
Auto Approve	An option available in this package that automatically approves claims and generates bills without user intervention.
Claim	A set of codes and fees grouped together to bill the responsible party for services rendered.
Claim Editor	Software that allows users to make modifications to third party insurance claims and to approve those claims within the third party billing software.
Claim Generator	Software that runs in the background that gathers data from PCC and patient registration in order to generate claims.
Claim Number	Number assigned to the claim, which will be sent to a billable entity.
Claim Summary	Abbreviated summary of key information in the claim.
Coinsurance	The portion of percentage of the Medicare-approved amount that a beneficiary is responsible for paying.
Covered Days	Number of days covered by the primary payer, as qualified by the payer organization.
Deductible	The amount of expense a beneficiary must pay before insurance benefits begin payment for covered services.
Diagnosis	Identifying a disease from its signs and symptoms.
Discipline	Code indicating discipline(s) order by physician.
Drug File	List of Drugs that can be dispensed to a patient during a visit. The

	medications available for selection are restricted to whatever entries exist in the Drug file at each site. This file is maintained by the Pharmacy and should reflect all locally prescribed take home drugs.
Electronic Media Claims (EMC)	Electronic transmissions of claims.
Eligibility	A defined period of time that a patient is enrolled in prepaid health programs.
Fee-for service	A payment system by which doctors, hospitals, and other providers are paid a specific amount for each service performed as identified by a claim for payment.
Fee Schedule	Medicare's system for paying physicians fees. The schedule, which went into effect on January 1, 1992, assigns a dollar value to each physician service based on work, medical practice costs, and malpractice insurance costs. Each of these three factors is adjusted for the geographic variation in costs.
HCFA-1500	Form sent to the proper Medicare carrier requesting that Medicare Part B payment be made for covered services.
HCPCS Procedure Code	Procedure codes that identify services so that appropriate payment can be made. These codes are required for many specific types of outpatient services and a few inpatient services.
ICD-9 Code	Diagnosis code which describes the principle diagnosis (i.e., the condition established after study to be chiefly responsible for causing this hospitalization).
Insurer File	File consisting of Insurance companies which IHS has authorization to bill for services provided to IHS patients.
Itemized Bill	A bill generated with a detailed description of each item and cost of the item.
Medicaid	A federally aided, state operated program that provides medical benefits for certain low-income persons.
Medicare	A national health insurance program for people 65 years of age and older, certain younger disabled people, and people with kidney failure. It is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).

Medicare Part A Coverage	Insurance that pays for medically necessary inpatient hospital care, skilled nursing facility or psychiatric hospital, and for hospice and home health care for eligible patients.
Medicare Part B Coverage	Insurance that pays for medically necessary doctor services and many other medical services and supplies for eligible patients.
Medicare Supplement Policy	A health insurance policy that pays certain costs not covered by Medicare such as coinsurance and deductibles.
Modifier	Two position codes serving as modifiers to HCPCS procedures.
Non-Beneficiary	Person not eligible to receive services at IHS or tribal facilities due to regulation, policies, and procedures.
Non-Covered Days	Days of care not covered by the primary payer.
Payment Posting	The entering of payment information related to a bill by category, such as payment amount, deductible amount, co-insurance amount, etc. in order to account for the entire amount billed.
Preferred Providers	Physicians, hospitals, and other health care providers who contract to provide health services to persons covered by a particular health plan.
Primary Care Provider	The provider that serves as the initial interface between the member and the medical care system. The PCP is usually a physician, selected by the member upon enrollment, who is trained in one of the primary care specialties who treats and is responsible for coordinating the treatment of members assigned to his/her panel.
Private Insurance	Health insurance other than Medicare or Medicaid. Coverage is usually based on current employment or current employment of a family member.
Procedure Codes	Codes that identify the principal procedure(s) performed during the period covered by a bill.
Revenue Code	Code used for outpatient ancillary services provided.
Table Maintenance	Managing table files associated with the billing system.
UB-92	National Uniform Billing Form used for billing for hospital and hospital clinic services implemented in October 1993.

14 APPENDIX A: Third Party Billing EMC Preparation

Caution: Please notify the Data Center **in writing** IF you will be transmitting your own Medicare outpatient claims through RPMS as of a specific visit date. This applies to paper claims (forms) or electronic transmissions.

Step 1: Contact the Site Manager.
The Site Manager should verify "dossavex" is part of your UNIX path.

Step 2: Change EMC file preference to HOST FILE

a. Select the Third Party Billing System option by typing TMTP at the main menu prompt.

b. Type SITM at the Table Maintenance Menu option prompt.

c. Type HOST FILE at the "EMC File Preference....." prompt.

d. Press the up-hat key (^) until the system returns to main menu prompt.

Step 3: Update the mode of export for all desired visit types in the insurer file
(Repeat this portion as visit types are added.)

a. Select the Third Party Billing System option by typing TMTP at the main menu prompt.

b. Type INTM at the Table Maintenance Menu option prompt.

c. Type EDIN at the Insurer File Menu option prompt.

d. Type 1 and press the Return key at the "Select DESIRED ACTION: 1//" prompt.

e. Type Y at the "Screen-out Insurers with status of Unselectable? Y//" prompt.

f. Type Medicare (or the name of the desired insurer) at the "Select INSURER:" prompt.

g. Press the Return key through the following prompts until you see the "Select VISIT TYPE:" prompt.

h. Type OUTPATIENT (or the name of the desired visit type) at the "Select VISIT TYPE:" prompt.

i. Press the Return key through the following prompts until you see the "Mode of Export:" prompt.

j. Type UB-92-E at the "Mode of Export ....: default value//" prompt.

k. Repeat steps 3h-3j until all visit types are updated.

l. Press the up-hat key (^) until the main menu prompt appears.

Step 4: Update AO control number in insurer file

a. Select the Third Party Billing System option by typing TMTP at the main menu prompt.

b. Type INTM at the Table Maintenance Menu option prompt.

c. Type EDIN at the Insurer File Menu option prompt.

d. Type 1 and press the Return key at the "Select DESIRED ACTION: 1//" prompt.

e. Type Y at the "Screen-out Insurers with status of Unselectable? Y//" prompt.

f. Type Medicare (or the name of the desired insurer) at the "Select INSURER:" prompt.

g. Press the Return key through the following prompts until you see the "AO Control Number:" prompt.

h. Type 00400 (or the number assigned by the NAIC) at the "AO Control Number..:" prompt. 00400 is the usual number for Medicare.

i. Press the up-hat key (^) until the main menu prompt appears.

Step 5: Enter EMC Data in the Insurer File

a. Select the Third Party Billing System option by typing TMTP at the main menu prompt.

b. Type INTM at the Table Maintenance Menu option prompt.

c. Type EDIN at the Insurer File Menu option prompt.

d. Type 1 and press the Return key at the "Select DESIRED ACTION: 1//" prompt.

e. Type Y at the "Screen-out Insurers with status of Unselectable? Y//" prompt.

f. Type Medicare (or the name of the desired insurer) at the "Select INSURER:" prompt.

g. Press the Return key through the following prompts until you see the "EMC SUBMITTER ID:" prompt.

h. Type the ID number assigned by the third party (i.e., Medicaid) at the "EMC SUBMITTER ID:" prompt.

i. Type the password assigned by the third party at the "EMC PASSWORD:" prompt.

j. Type T for test mode or P for production mode at the "EMC TEST INDICATOR:" prompt.

k. Press the up-hat key (^) until the main menu prompt appears.

Step 6: Verify that the user has a "V" for his file manager access code

a. Open the FileMan program.

b. Type 1 (Enter Or Edit File Entries) at the "Select OPTION:" prompt.

c. Type NEW PERSON at the "INPUT TO WHAT FILE:" prompt.

d. Type FILE MANAGER ACCESS CODE at the " EDIT WHICH FIELD:" prompt.

e. Press the Return key at the "EDIT FIELD:" prompt.

f. Type the user's name at the "Select NEW PERSON NAME:" prompt.

g. Type V and press the Return key at the "FILE MANAGER ACCESS CODE:" prompt.

h. Press the up-hat key (^) to exit.

Step 7: Approve the claims (steps 1-6 must be complete first).

14.1 RPMS File (Batch) Creation

Step 1: Locate the Electronic Media Claims Menu in the Third Party Billing package.

Step 2: Select the Third Party Billing System option by typing EM3P at the Electronic Media Claims Menu prompt.

Step 3: View the summary of bills ready for submission

a. Select the Electronic Media Claims option by typing SUEM at the main menu prompt.

b. A message: `Summary information about batches ready to submit` is displayed.

c. Type Y or N and press the Return key at the "Show Detail?" prompt. (Type Y if you wish to see an itemized list.)

d. If you typed Y in step 3c, type the number of the insurer/visit you wish to see at the "What sequence number (1-2):" prompt. The system displays each bill in the batch. If you typed N in step 3c, skip to step 3e.

e. If everything looks OK, proceed to step 4. Otherwise, return to the Edit a Claim option and make the necessary corrections.

Step 4: Create the EMC File

a. Select the Electronic Media Claims option by typing CREM at the main menu option. The summary information will be displayed.

b. Type the number of the insurer or visit for the batch at the "What sequence number (1-3):" prompt.

c. Type Y or N and press the Return key at the "Proceed?" prompt. The following message is displayed on your computer screen:

```
ENTRY CREATED IN 3P TX STATUS FILE .
LOCATION:  ALBUQUERQ HO@1546      (or your site)
VISIT TYPE:  OUTPATIENT
```

d. If the `Cannot create entry in 3P TX STATUS FILE` message appears on your screen, verify that the user has a "V" in his FileMan Access Codes (see step 6 in section 14.0).

e. Type or accept /usr/spool/uucppublic/ at the "Enter Path:" prompt and press the Return key.

f. Type a valid filename at the "Enter FILE NAME:" prompt and press the Return key. The following message will be displayed on your screen:

```
BATCH #1460087

Writing bills to file. . . .
Finished.
```

g. The message under step 4c will be repeated for each visit type. Repeat steps d-e.

Step 5: View Batch Summary

a. Select the Electronic Media Claims option by typing BSEM at the main menu prompt.

b. Type a valid date at the "Select beginning export batch:" prompt.

c. Type a valid date at the "Select ending export batch:" prompt.

d. Type the name of a print device and press the Return key at the "Enter DEVICE:" prompt. The batch summary will be displayed on the device you chose.

Step 6: Recreate an EMC File

If the original EMC file is deleted, recreate it by following these steps:

a. Select the Electronic Media Claims option by typing RCEM at the main menu prompt.

b. Type a valid date at the "Select 3P TX STATUS EXPORT DATE:" prompt.

c. Type or accept /usr/spool/uucppublic/ at the "Enter Path:" prompt and press the Return key.

d. Type a valid filename at the "Enter FILE NAME:" prompt and press the Return key. The following message will be displayed on your screen:

```
Writing bills to file. . . .
Finished.
```

14.2 Save File From UNIX To Diskette

Step 1: Obtain a PC formatted diskette. Do not format on UNIX machine.

Step 2: Ask someone with root access (usually the site manager) on the UNIX machine to meet you in the computer room.

Step 3: Take the list of files you created in RPMS and the diskette to the computer room.

Step 4: Give the list and diskette to the Site Manager (SM).

Step 5: The SM will log on to the UNIX (RISC) machine as root and inserts the diskette in the disk drive.

Step 6: At the UNIX prompt, the SM will type **dossavex** filename

Step 7: The SM will repeat step 6 for each file created. This process must be done one file at a time.

Step 8: The SM will log off the UNIX machine, remove the diskette, and return it to you.

Step 9: The diskette now contains the files you need to transmit. Take it back to your PC.

14.3 Transmit Files To Medicare If FI Is BCBS Of Texas

Step 1: Take the diskette that contains the files to PC with Modem and ProComm.

Step 2: Access ProComm software.

Step 3: Dial Medicare (972-889–5465) through the ProComm software.

Step 4: Log into the Medicare system.

```
Welcome to rEDI - link Blue ! ! !  (PROD2)
Customer Support: TX - CO - NM  (972) 766 - 5480
                                              MD  (410) 527 - 5654
Please Login:
type in login number (usually 6 numerics) <RETURN>
Password? type in password (IHSIHS?) <RETURN>  (You won't see what you are
typing.)
                              user logged in at date and time
                                     last login  at date and time

Press <RETURN> to continue  -> <RETURN>
```

NOTE: Texas Local Format is not supported on rEDI-link Blue.

It is strongly recommend use of PKZIP V 2.04g or compatible compression software. This will significantly REDUCE data transmission costs.

Step 5: Select the Upload option from the main menu by typing 2 at the "Selection:" prompt and pressing the Return key.

```
                                Welcome to rEDI-link Blue
                  ========================

                1.  (D) ownload
                2.  (U) pload
                3.  (L)  ist Files in Mailbox
                4.  (H)  elp
                5.  (Q)  uit

                Selection:  2 <RETURN>
```

Step 6: Upload the file by following the instructions that appear on your computer screen.

a. Click on the open file folder icon.

b. Select the file you wish to send. (You can only send one at a time).

c. Click the OK button.

```
<<<<  UPLOAD A FILE  >>>>

**** Select Protocol:
                K  for Kermit
                X  for XMODEM
                Y  for YMODEM
                Z  for ZMODEM

                 or  Q  for QUIT    Z

**** Please place your PC in ZMODEM mode to send the file.
**B0100000027fed4
```

Step 7: When the upload is complete, ProComm will display the message `Transfer Completed Successfully` on the bottom status bar.

```
**** Transfer COMPLETED SUCCESSFULLY ****
Press <Return> to continue
Application Finished - Returning to Menu
```

14.4 To Download Medicare's Response To Your Transmission

Step 1: Log into the Medicare system and select the Download option by typing 1 at the "Selection:" prompt and pressing the Return key.

```
                  Welcome to rEDI-link Blue
                    ======================

                  1.  (D) ownload
                  2.  (U) pload
                  3.  (L)  ist Files in Mailbox
                  4.  (H)  elp
                  5.  (Q)  uit

                  Selection:  1 <RETURN>
```

Step 2: Select the ZMODEM protocol for your computer by typing Z at the "or Q to Quit:" prompt.

```
>>>>  DOWNLOAD A FILE  <<<<

**** Select Protocol:
                  K  for Kermit
                  X  for XMODEM
                  Y  for YMODEM (BATCH)
                  Z  for ZMODEM

                   or  Q  to QUIT    Z
Do you wish to download all of the files in the mailbox? (Y/N)  Y
Press Y/N to continue or q to quit

**** Please place your computer in ZMODEM to receive the files.
```

Step 3: Type Y at the "Do you wish to download all of the files in the mailbox? (Y/N):" prompt. The computer will download the files and the `Transfer Completed Successfully` message will appear and you will be returned to the main menu when it is finished.

```
**** Transfer COMPLETED SUCCESSFULLY ****
Press <RETURN> to continue
Application Finished - Returning to Menu
```

Step 4: Exit the Medicare System
Type 5 at the "Selection:" prompt and press the Return key.

```
                          Welcome to rEDI-link Blue
                    ======================

                  1.  (D) ownload
                  2.  (U) pload
                  3.  (L)  ist Files in Mailbox
                  4.  (H)  elp
                  5.  (Q)  uit

                  Selection:  5<RETURN>
User _____________________ logged out at date and time
```

Step 5: Exit ProComm

> **NOTE:** When DOWNLOADING (1) the response file to your PC, the files are placed in C:\PROWIN\DNLOAD. Each day you send a transmission to Medicare, the response files will overwrite the ones from previous days. The numbering scheme starts over with one (1). If you wish to keep these files, you will need to move them to a different directory on your PC.

14.5 NM Medicaid billing through Consultec/ ACE$

To set up RPMS for Consultec/ ACE$ billing:

a. The mode of export will need to be changed in the Insurer File for all visit types from UB92-E V4 to UB92-E V5. Claims created before this version will need to be manually changed to the new mode of export.

b. Users should use the same software they are currently using to submit claims to ACE$, but should use 866-589-2798 for the phone number. This number can be verified and updated in the COMMUNICATIONS tab on the top of the applications. There maybe a new login and password that will be assigned by ACE$. If there is not, use your current login and password.

c. Once logged in, choose the menu item 'UB92'. This is how you will upload your claims. Follow the procedure you are currently using to upload your claims.

15 APPENDIX B: Third Party Billing Location Setup

15.1 Setup the Billable Location In Accounts Receivable

Step 1: Open the Accounts Receivable package.

Step 2: Select the Manager option by typing MAN at the main menu prompt.

Step 3: Select the Parent/Satellite Edit option by typing PSE at the MAN menu.

Step 4: Select the home location that pertains to your area and set up.

(For more information on this setup, refer to the IHS Accounts Receivable User Manual.)

15.2 Setup Site Parameter Function In Third Party Billing

Step 1: Select the Table Maintenance option by typing TMTP at the main menu prompt.

Step 2: Select Site Parameters option by typing SITM at the TMTP menu.

Step 3: Press the Return key through the following prompts until you see the "USE A/R PARENT SATELLITE SETUP?:" prompt.

Step 4: Type Y or N at the "Use A/R Parent Satellite Setup?" prompt.

16 Appendix C: Setup for Freestanding Clinics and Medicare Part B Billing

Type Y at the "Medicare B Only:" prompt in the Locations File Maintenance option (section 8.5.1). If the site is a freestanding clinic that can bill Medicare Part B only, you should type Y.

Before your freestanding clinic site can bill Medicare Part B, you must make Medicare billable and enter address information as needed. This can be done in the Table Maintenance menu option under the Insurer Edit menu.

> **NOTE:** The name of the Medicare entry should be 'MEDICARE' as the program looks for that exact name in the 3P routines. **Do not change the name.**

Follow the same steps for setting up Railroad Retirement.

Freestanding clinic sites need to populate the Medicare Number in the Location file with the Medicare group number assigned to them. They can do this through the Location Edit Menu in the Table Maintenance option.

Do a back billing check back to 7/1/2001 to pick up Medicare claims. Only one claim will be created with visit type 999.

> **NOTE**: there is no need to run the post init routine ABMDMEDB at a freestanding clinic; this routine splits claims from existing claims. If this routine is run by mistake, there is no need to worry if they have entered "YES" at the new "Medicare B Only" field. If the user has already run the routine and has two claims per visit, he/she will need to cancel the facility claim (the one that is not visit type 999). Some sites are waiting on the Medicare Eligibility Upload patient reg patch #15 and must install that patch before proceeding with Medicare Part B billing.

17 Appendix D: Adjustment Categories Passing Between A/R and Third Party

Specific adjustment categories will now pass correctly from A/R to Third Party Billing. This allows the secondary insurer bill amount to be calculated properly in the Third Party Billing package. This will affect the process in which secondary bills are sent. This modification to the Third Party Billing system will allow the user to view previous adjustment information and allow the user to more accurately bill secondary payers.

Upon answering 'YES' at the claim approval prompt, the system will display the summary page and any previous adjustments that have been posted. Please note that the CURRENT ADJUSTMENTS that are displayed are from the Third Party Bill file. This information will only appear if the payment information was rolled back from the Accounts Receivable system.

```
                                    SUMMARY
================================================================================

                              Previous                                  Bill
       Form      Charges      Payments   Write-offs   Non-cvd      Amount
     ----------  ----------  ----------  ----------  ----------  ----------
     UB-92            75.00       41.00       24.00        0.00       10.00
                 ==========  ==========  ==========  ==========  ==========
                      75.00       41.00       24.00        0.00       75.00

Do You Wish to APPROVE this Claim for Billing? YES

CURRENT ADJUSTMENTS:
         Write-off:  24              Co-insurance:  10
Include any adjustments in billed amount?? Y//
```

Figure 17-1: Summary of Adjustments Page

If the user answers No at the "Include any adjustments in billed amount?? Y//" prompt, the system will continue to approve the claim into a bill with the payments and adjustments shown in the summary screen.

If the user answers Yes at the "Include any adjustments in billed amount?? Y//" prompt, the system will indicate the amount to write off on the bill. The user will need to specify the amount they want to include *in addition* to the co-pay or deductible from the prior bill. The system will default to the amount listed in the 'Write-offs' column.

```
Write-off Amount to bill:  24// 15

Ok, I will add $15 to $10 for a total billed amount of $25
OK?? Y//
```

Figure 17-2: Setting Up Write Offs

The user may then add the amount they wish to bill the secondary payer. The system will add that amount to any previous co-pay or deductible amounts then confirm the total billed

amount. If the amount is not correct, the user has the option of correcting this by answering 'No'. If no action is taken, the claim will approve into a bill.

> **Note**: This function works best with the crossover and secondary setup.

18 Appendix E: KIDSCARE and AHCCCS

18.1 New KIDSCARE Data Checks

Patch 9 also modified many routines to perform the same checks for KIDSCARE as those that get performed for Medicaid (ie: where to find eligibility).

Historically, KIDSCARE plans were entered on Page 7 (Private Insurance) of Patient Registration as Third Party Billing did not accommodate itemization of the claim plus the plan would remain as the AHCCCS or Arizona Medicaid plan.

As of Patch 13 to Patient Registration (Version 6.0), the Medicaid Eligibility page (page 5) has been modified to allow the user to enter KIDSCARE plans. If the site chooses to relocate their KIDSCARE eligibility information to Page 5 from Page 7, they must ensure the following criteria are being followed:

Eligibility should never be deleted! The site must end eligibility on Page 7 and start eligibility on Page 5. Eligibility cannot be deleted right away as the Third Party Billing system relies on information previously stored when the claim was approved. If eligibility is deleted right away, eligibility information on reprinted bills will not print completely.

The insurer file must be set up with the correct Type of Insurer. Kidscare has it's own insurer type labeled 'K'. Kidscare or CHIP plans must have this entry in the Insure file.

18.2 Printing Arizona KIDSCARE Coverage Information

If the patient has Arizona Medicaid coverage and KIDSCARE is entered as plan name on page 5 in Patient Registration, KIDSCARE information will print on the claim instead of Arizona Medicaid. Please refer to the addendum section titled KIDSCARE Data Checks for setting up this process.

18.3 AHCCCS Accommodations for the HCFA 1500

The electronic HCFA 1500 has been modified for AHCCCS to zero fill the Disallowed Other, Allowed Amount, Deductible Amount, and Coinsurance Amount fields in the Insurance Information record (DA1).

18.4 Setting up AHCCCS to Bill Zero Claims

1. Set up the Visit Type. The site must add Visit Type (50) Zero-Pay Claim to the Visit Type Maintenance file located in Table Maintenance. The system will prompt the user for the following:

-NAME: ZERO-PAY CLAIM//

-UB-92 BILL TYPE:

-Select CLINIC:

The user may press the Return key at these prompts. Do not enter information under the 'Select CLINIC:' prompt.

2. Set up the Insurer File. The insurer file needs to be populated with the 'Zero-Pay Claim' visit type. Add the information **exactly** as it appears in the Outpatient visit type. If billing flat rate, make sure the flat rates are entered.

3. Claim Editing/Approving. When in the claim editor, the Visit Type on Page 1 will need to be changed to '50' or 'Zero-Pay Claim'. Please ensure the payer is AHCCCS or Arizona Medicaid.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 1 ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: GARCIA,RENEE  [HRN:6484]                        Claim Number: 20797
............................ (CLAIM IDENTIFIERS) ............................

                [1] Clinic.............: GENERAL
                [2] Visit Type.........: ZERO-PAY CLAIM
                [3] Bill Type..........: 131
                [4] Billing From Date..: 07/10/2001
                [5] Billing Thru Date..: 07/10/2001
                [6] Super Bill #.......:
                [7] Mode of Export.....: HCFA-1500-E
------------------------------------------------------------------------------
WARNING:071 - EMPLOYMENT INFORMATION UNSPECIFIED
------------------------------------------------------------------------------
Desired ACTION (View/Next/Jump/Back/Quit): N// N

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 2 ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: GARCIA,RENEE  [HRN:6484]                        Claim Number: 20797
................................ (INSURERS) ................................

To: ARIZONA MEDICAID                    Bill Type...: 131
    PO BOX 26669                        Proc. Code..: ICD9
    PHOENIX, AZ  46512                  Export Mode.: HCFA-1500-E
                                        Flat Rate...: 185.00

             BILLING ENTITY           STATUS       POLICY HOLDER
     ============================  ========== ==============================
[1]  ARIZONA MEDICAID               ACTIVE      GARCIA,RENEE
------------------------------------------------------------------------------
WARNING:073 - EMPLOYER NAME UNSPECIFIED
------------------------------------------------------------------------------
Desired ACTION (View/Next/Jump/Back/Quit): N//
```

Figure 18-1: Setting Up AHCCCS to Bill Zero Claims

4. Once approved, the zero amounts will appear on the electronic batch file. This applies to AHCCCS claims only. If printing hardcopy, the user must first set up the zero pay batch

using the Form Locator Override function. The example in Figure 7 may be used as a guide in Form Locator Override (FLTM):

```
Select 3P INSURER:    ARIZONA MEDICAID
Select 3P EXPORT MODE FORMAT: 14  HCFA-1500 Y2K        HCFA 1500 Y2K version

     Select one of the following:

          10        RESERVED FOR LOCAL USE
          11        BOX 11C - INSURANCE PLAN/PROGRAM NAME
          19        RESERVED FOR LOCAL USE
          24        LINE ITEMS
          32        WHERE SERVICES RENDERED
          33        BILLING INFO

Select Form Locator: 24  LINE ITEMS
Enter visit type, or leave blank for all. 50  ZERO-PAY CLAIM

     Select one of the following:

          1         A1 - DOS FROM
          2         A2 - DOS TO
          3         B - POS
          4         C - TOS
          5         D - HCPCS
          6         E - DIAGNOSIS
          7         F - CHARGE
          8         G - UNITS
          9         H - EPSDT
          10        I - EMG
          11        J - COB
          12        K - LOCAL USE

Which Section?: 12  K - LOCAL USE

     Select one of the following:

          1         ADD/EDIT
          2         DELETE

Add or Delete Entry?: ADD/EDIT//
DATA VALUE: 0/0
```

Figure 18-2: Form Locator Override (FLTM) Example

19 Contact Information

If you have any questions or comments regarding this distribution, please contact the ITSC Help Desk by:

Phone: (505) 248-4371 or
(888) 830-7280

Fax: (505) 248-4199

Web: http://www.rpms.ihs.gov/TechSupp.asp

Email: RPMSHelp@mail.ihs.gov